PROCEEDINGS OF THE FEDERAL-PROVINCIAL DEPARTMENTAL CONFERENCE ON FAMILY PLANNING

Ottawa
March 22 – 23, 1971

DEPARTMENT OF NATIONAL HEALTH AND WELFARE

Department of National Health and Welfare
FEDERAL-PROVINCIAL DEPARTMENTAL CONFERENCE
ON FAMILY PLANNING

PARTICIPANTS

Chairmen

Dr. E. A. Watkinson
Assistant Deputy Minister (Health Services)
Department of National Health and Welfare

Dr. R. B. Splane
Director General
Welfare Assistance and Services
Department of National Health and Welfare

Alberta

Mr. Gerald Archibald
c/o Social Planning and Development Branch
Alberta Department of Social Development
Executive Building
Jasper Avenue & 109th St
Edmonton 14, Alberta

Mr. J. P. Matheson
Director, Branch of Health Education
Division of Local Health Services
Alberta Department of Public Health
401 Administration Bldg.
109th St. & 98th Avenue
Edmonton 6, Alberta

Saskatchewan

Mr. Blaine Bethune
Program Consultant
Department of Welfare
2240 Albert Street
Regina, Saskatchewan

Dr. Hugh Grocott
Director, Child Health Division
Regional Health Services Branch
Department of Public Health
311 Albert Street
Regina, Saskatchewan

Manitoba

Mrs. Gloria Plesniarski
Office of Research and Planning
Manitoba Department of Health and Social Services
Room 411, 401 York Avenue
Winnipeg 1, Manitoba

Ontario

Mr. Donald Cornish
Research Officer
Research & Planning Branch
Department of Social & Family Services
Hepburn Block, Queen's Park
Toronto 5, Ontario

Dr. Roch Khazen
Medical Officer
Maternal and Child Health Service
Special Health Services Branch
Ontario Department of Health
Hepburn Block, 9th Floor
Parliament Buildings
Toronto, Ontario

Quebec

Mlle Hélène Dutil
Psychologue
Direction génèrale de la Planification et Recherche
Ministère des Affaires Sociales
1075, chemin Ste-Foy
Québec, Québec

New Brunswick

Mr. Georgio Gaudet
Director of Staff Development
New Brunswick Dept. of Welfare
Fredericton, N.B.

Dr. J.R. Allanach
District Medical Health Officer
New Brunswick Department of Health
P. O. Box 5001
Fredericton, N.B.

Nova Scotia

Mr. Kevin Burns
Director of Family and Child Welfare
Nova Scotia Department of Public Welfare
Halifax, Nova Scotia

H.B. Colford, M.D. M.P.H.
Director, Child and Maternal Health
Nova Scotia Department of Public Health
Box 488
Halifax, N.S.

P.E.I.

Mr. E. A. MacDonald
P.E.I. Department of Welfare
Box 2000
Charlottetown, P.E.I.

Miss Bernice Rowland
Director, Public Health Nursing
Department of Health
P.O. Box 3000
Charlottetown, P.E.I.

Newfoundland

Mr. Roy Tiller
District Supervisor
St. John's Regional Office
Department of Social Services
and Rehabilitation
Provincial Government Building
Harvey Road
St. John's, Nfld.

Dr. David Severs
Chief Medical Health Officer
Government Building
Harvey Road
St. John's, Nfld.

Yukon

Mr. Maurits Van Der Veen
Assistant Director of Social Welfare
Government of the Yukon Territory
Whitehorse, Yukon

Miss Tania Nolde
Public Health Nurse
Medical Services, Yukon
Zone
Whitehorse General Hosp.
Whitehorse, Yukon

Northwest Territories

Mr. S. A. Huesing
Chief of Health Insurance Services
Government of the Northwest Territories
302 Corona Building
10645 Jasper Avenue
Edmonton 14, Alberta

(Named as the only representative of Northwest Territories)

Invited Guests

George F. Brown, M.D., M.P.H.
Director, Population and Health Sciences
International Development Research Centre
500 Pebb Building, 2197 Riverside Drive
Ottawa 8, Ontario

C.J.G. Mackenzie, M.D., C.M., D.P.H., C.R.C.P., F.R.S.H.
Associate Professor and Chairman, Department of
Health Care and Epidemiology, and
Director, Division of Public Health Practice
University of British Columbia
Room 300, Wesbrook Building
Vancouver, B.C.

Serge Mongeau, M.D., M.A.
Directeur
Le Centre de Planning Familial du Québec Inc.
65 est, rue Sherbrooke
Montréal 130 (P.Q.)

Mr. Brian M. Strehler
Executive Director
Family Planning Federation of Canada
96 Eglinton Ave. E.
Toronto 315, Ontario

Department of National Health and Welfare

Dr. R. H. Lennox
Director
Child and Adult Health Directorate

Mr. E. Smit
Consultant
Welfare Assistance and Services

Dr. R. A. Armstrong
Director, Medical Care
Health Insurance and Resources Branch

Dr. P. Banister
Medical Consultant
Child and Maternal Health

Dr. J. Bishop
Director, Drug Advisory Bureau
Food and Drug Directorate

Miss A.Y. Burns
Educational Consultant
Child and Maternal Health

Dr. R.W. Campbell
Assistant Director, Program Administration
Food and Drug Directorate

Dr. J.A. Dupont
Acting Director
Health Grants

Dr. W. H. Frost
Senior Medical Adviser, Health and Treatment
Medical Services Branch

Mrs. C. R. Heggtveit
Supervisor, Public Health Section
Research and Statistics Directorate

Mr. L. James
Information Officer
Information Services

Dr. G.H. Josie
Assistant Director General (Program Development)
Health Services Branch

Dr. M. Kelly
Principal Program Officer
Welfare Research

Mr. C.N. Knight
Consultant
Public Assistance Policy

Dr. W.P. Mickelson
Medical Officer
Medical Care

Mlle D. Moncion
Consultant, Community Services
Canada Assistance Plan

Mr. M.E. Palko
Consultant in Health Education

Mrs. F. Paltiel
Public Health Section
Research and Statistics Directorate

Mr. N.N. Papove
Principal Program Officer
Welfare Manpower Utilization and Development

Mrs. E.M. Pope
Chief, Educational Services Division
Food and Drug Directorate

Mr. F.W. Price
Assistant Director (Health)
Information Services

Mrs. V. Splane
Principal Nursing Officer

Dr. R. W. Tooley
Assistant Director General (Operations)
Health Services Branch

Miss C.A. Swinton
Assistant Director, Studies and Projects
Victorian Order of Nurses

FEDERAL-PROVINCIAL DEPARTMENTAL CONFERENCE
ON FAMILY PLANNING
MARCH 1971

The meeting was opened by Dr. Watkinson who welcomed participants on behalf of the Minister and Deputy Ministers of the Department of National Health and Welfare.

Dr. Watkinson -

In our recent letter of invitation to the Deputy Ministers of Health and Welfare or their counterparts throughout Canada, attention was drawn to the announcement of last September of the Minister of National Health and Welfare, the Honourable John Munro, concerning proposals for a Canada-wide family planning program of information, training and research. In announcing this Federal government program, Mr. Munro said that the government recognizes and supports the right of Canadians to exercise free individual choice in the practice of family planning. He said his department would encourage research in this field through grants and contracts to other agencies as well as within the department and will, in collaboration with provincial governments and private agencies, be prepared to undertake the dissemination of family planning information. In the area of training, the greatest need would seem to be in preparing health and welfare professionals to become more effective. The Minister also pointed out that a number of provinces mentioned, too, that there is good reason to believe that effective programs for family planning would reduce the incidence of unwanted children, of child neglect, abandonment, desertion, welfare dependency and child abuse. He also added that the government has been concerned with Canada's rate of progress in reducing infant mortality, being outranked by countries having national family planning programs.

At this point I think it would be useful to provide a little of the background leading to the present meeting. For the past three to four months we have had a small group within the department giving consideration to the implementation of the announcement by the Minister. This departmental group is made up of officials from both the welfare and the health sides of the department and reflects our intention of making this a joint health and welfare endeavour. In order to maintain liaison with the international aspects of family planning, Dr. George Brown, the Director of Population and Health Sciences, International Development Research Centre, has participated in several of our discussions. We hope this can continue.

In early February of this year, we had reached the point where we had some idea as to what a departmental or Canada-wide program should consist of, and also an idea of what

we were capable of funding through grants-in-aid and joint federal-provincial shared-cost programs. We then invited individual experts and representatives from professional and voluntary agencies across Canada-agencies already active in the field-to an ad hoc meeting in Ottawa. At that meeting we attempted to determine the most immediate needs, to set priorities, and to provide information concerning the ways in which we might be able to provide financial assistance. In my view, it was a most productive meeting. Since then, members of both the health and welfare sides of the Department have been very active in implementing certain aspects of the program. We hope these will tie-in with what you may want to do in family planning.

This brings us to to-day's meeting and, as stated in our letter of invitation, its purpose is to share views on the implementation of a federally-initiated Canada-wide program of family planning. We hope that our discussions can centre primarily around the pivotal issues of public information, research and training.

May I now turn you over to Dr. Splane.

Dr. Splane -

Dr. Watkinson, my task is a very easy one because you have expressed for both sides of the department our welcome and the satisfaction that we feel in having organized this meeting on rather short notice and receiving such a good response from across the country. I might mention that Dr. Willard, the Deputy Minister of National Welfare, had been hoping that he could be here at this time to express his very warm interest in the subject of family planning, He was acting as both Deputy Minister of Health and Deputy Minister of Welfare during the period in 1969-1970 when much of the initial work was done in developing the proposals that went forward to Cabinet. He has a continuing interest in the subject from that involvement and from much earlier ones during which he was involved in UNICEF and the Social Development Commission of the United Nations where the question of family planning internationally was drawn to his attention.

The type of collaboration that has been characteristic of the health and welfare side of the department has already been touched on by Dr. Watkinson. Two of my colleagues, Mr. Eric Smit and Mr. Norman Knight were particularly involved in that collaboration from the welfare side. Mr. Knight is here with me. He is moving from his role, wholly in the Canada Assistance Plan, to taking up full responsibilities in the field of family planning.

The nature of the welfare interest in family planning does not require any kind of elaboration by me. The persons in the welfare fields that are involved in child welfare and in family welfare, in trying to cope with the causes of poverty

and the means of dealing with it, will know how relevant is the question of the right of individuals in all economic groups, but particularly in the disadvantaged groups, to have access to family planning information and family planning materials. It is very clearly a matter that we have been conscious of but not very effective in on the welfare side until quite recent years. The main focus of our interest in this conference, on the welfare side, is to present, as clearly as we can, the kind of resources that we now have available, the kinds of programs - and they are essentially the Canada Assistance Plan and the National Welfare Grants Program - and to let you know what they now do and, in effect, to say how adequate they are. For example, are they going to be capable in their present form of assisting in the development of the necessary type of family planning programs across the country and, if not, what improvements or additional input to them are required? We will be listening, therefore, with particular interest after having presented an indication of what we have as well as to what the provincial representatives have to say on those issues so that we can go on to the next stage in developing a clear, effective departmental program.

Dr. Watkinson introduced Dr. R. H. Lennox.

Dr. Lennox -

Our present working definition of family planning includes child spacing and limitation of family size and, by inference, when the family size has been reached, ways to maintain the desired number of children. The family planning program was initiated in 1969. In reviewing the Canadian situation, we find the infant mortality rate, compared to other countries of the world, is now at 12, which means there are 11 other countries with improved rates compared to the Canadian rate. In the mortality rate, in 1968, Canada ranked seventh in the world. The most recent statistics (1969) lists Canada's maternal mortality as 13th. If we look at other programs involving other countries we find they concentrate, with the exception of one country, on intensive family planning programs particularly directed to mothers who are considered a risk. If these risk factors are examined we find that age is one prominent factor, particularly mothers under 16 and those over 40. We find other definitions of high risk mothers, particularly those that have had one previous illegitimate child and those with a parity above four. I have a quotation from the New York Times of March 18th, 1971, in which Dr. Harris, Assistant Health Commissioner, New York City, states: "The risk of prematurity and the chance of infant death are 1.8 times greater for fifth, sixth and seventh babies as for the first four." In Miss M. Manisoff's book, "Family Planning, a Teaching Guide for Nurses," the infant mortality rate is increased by 45 per cent for those born to mothers with more than four previous pregnancies

We have parity as another risk factor. There are medical and obstetrical conditions, acute and chronic, which would prejudice the delivery of a healthy, well child. There are other high risk factors which vary according to the geographic location, the social-economic situation and the cultural groups so that the high risk list will fluctuate from one region and one area and differ across the country. These are the background purposes from the health standpoint for promoting the development of family planning programs. There are additional factors. Some children are conceived accidentally under unplanned, unwanted circumstances and their presence in the world is not looked on with great favour. As a result we find the unwanted child, the child with multiple types of deprivation syndromes. The methodology I am sure most of you are quite aware of, include the much talked about "pill" which has a high degree of success in preventing pregnancy. The second is the intra-uterine contraceptive device. It is useful in the multiparous and in many areas found to be extremely useful, particularly in populations in developing countries. The other methods are useful but of less security and these include the well-known diaphragm, condom, and as we get down the list, we get into the areas of foams and gels and spermicidal jellies and so on. These are again going down in reduced effectiveness compared to the pill and the IUD and there are other methods that involve rhythm and the sympto-thermique method, the temperature taking method. These are effective but to a lesser degree. There are developments that you are totally aware of, I'm sure, and the prosthoglandins that at the present time have great promise and possibly may become the penicillin of contraception. This is a very broad statement to make; however, it looks as if they have great potential. Much further work needs to be done before one can go any further but they do have the promise of something that looks most encouraging.

Dr. Watkinson -

Dr. Lennox, thank you very much. I am wondering if you would be prepared to include another important reason for family planning, that is, to reduce the number of requests for abortions.

Dr. Lennox -

This is a very good reason and the intensity or the success of our program in contraception will have a direct influence on the number of requests for abortions. There are a great number of welfare areas that I have not included and I am leaving this open for other speakers.

Dr. Splane -

Dr. Watkinson, I may want to refer in rather general terms to some of the reasons for the interest in the welfare field in developing a program of family planning but first let me turn to my colleague, Mr. Knight, for any comments that he

might wish to make.

Mr. Knight -

Thank you Dr. Splane. I am sure you are all aware of the inverse relationship between income and family size. The brief submitted to the Senate Committee on Poverty by the Family Planning Federation of Canada indicated a considerable, positive correlation between poverty, family size, child neglect, and behaviour disorders. These are all things which welfare agencies are concerned with and which are cropping up with increasing frequency. For example, at a conference last weekend I met the head of an institution for disturbed children in a large western city. I asked him for his views about the relationship between parents' desire for children and behavioural disorders. He said: "I can't give you statistics but I'm satisfied by 15 years' experience in the field that a high percentage of youngsters who end up with serious behavioural disorders are basically unwanted children." The Ottawa Citizen of March 15th reported that only 52 of 115 pregnant school girls in Metropolitan Toronto, included in a study covering the last six months of 1970, returned to school after their babies were born. This study was an attempt to obtain statistics about the effect of pregnancy on the schooling of adolescents and the need for community classes for pregnant students. Dr. Marion Powell, Assistant Medical Officer of Health, Scarborough, told a recent conference in Toronto on adolescent sexuality that pregnancy was the chief reason that girls dropped out of school. She said that increased sexual activity among high school students can be gauged by the number of pregnancies and the number of cases of V.D. She gave no statistics but said: "There are more pregnant girls in our schools; the illegitimacy rate is rising; the number of abortions performed on girls under the age of 18 is increasing; and young girls are appearing at family planning clinics requesting birth control." These are just a few examples, Mr. Chairman.

Dr. Watkinson -

Thank you Mr. Knight, this is very helpful. Perhaps Dr. Brown, you would like to comment at this point?

Dr. Brown -

I wish only to say Mr. Chairman, that these broad objectives coincide very closely with the family planning objectives now undertaken by many countries. My particular concern has been working with family planning activities in the developing world and I think the objectives outlined here and outlined in the agenda coincide very closely indeed with those in other parts of the world, not only the developing areas but in most of the more developed countries. I think one might emphasize point number one in the objectives - the individual free choice. To my

mind, a free choice means adequate information and I think this is a very important objective, that is, to assure that those people of most concern do have adequate information.

Dr. Watkinson -

Thank you Dr. Brown. I should perhaps mention that while we are discussing our understanding of what is family planning and reasons for family planning, we should be looking at our proposed objectives. Dr. MacKenzie, would you like to comment.

Dr. MacKenzie -

I think, Mr. Chairman, that my chief contribution, and probably Dr. Mongeau's chief contribution when he arrives, will be to give you some experiences in providing services. I think at this time that the objectives are excellent.

Dr. Watkinson -

Thank you. Now, have any of you around the table any questions or comment?

Mr. Tiller -

I would like to address my question to Dr. Lennox. Is there any research being sponsored by the federal government in regard to the methodology which you cited? That is, is there any research work going on in developing new methods or amplifying existing ones?

Dr. Lennox -

There is research across the country in some of these methods funded and financed through the Public Health Research Grant. However, there is another area of research I understand being done in one of the federal departments in the subject of prosthoglandins. The research up to now has been non-directive, coming from the field when the project proposal and request for grant support for this proposal therefore it is received from the periphery and to the central area according to what the research investigator considers of importance in the area of his work. It's non-directive, so that there has not been any suggestion of the type that is needed. It's up to the research investigator what he considers is an area of interest and importance to him. This is the way that it has been handled and managed up to the present time and maybe it will continue.

Dr. Brown -

Just a brief word. This is an area of considerable interest and concern both to the Department of National Health

and Welfare and the International Development Research Centre about which I'll be speaking later. We are concerned and trying to encourage further research-to work for a research policy that supports greater co-ordinated efforts in this field in Canada and elsewhere-and to follow along the lines that Dr. Lennox mentioned although we have some good methods. But the ones we have are far from perfect.

Dr. Grocott -

Is there anywhere a national policy as to family size, population as a whole vis-à-vis immigration policy? Is there anything in fact that we, as a province, would have to aim at to fit in with a national program? Or are we still just fumbling around thinking that every family ought to have about two, but not thinking in national or in international terms?

Dr. Watkinson -

I'm going to turn to Dr. Lennox for reply. It's a very good question.

Dr. Lennox -

A difficult one to answer. There is no population policy to my knowledge for the country. This is an extremely difficult area and extremely difficult to decide what the optimum population should be in 1975, 1980 and the year 2000. Many variables have to be taken into consideration, such as the economics and the social structure of the country. As a matter of fact, I don't know of any set population policy established by any country to optimize its numbers of people in relation to its industrial growth and development and the other needs projected for the five, ten, twenty-five year period. Now I may be corrected here and I wish someone would correct me if anyone knows of a population policy that has been established by any country. Many are working on it and trying to decide just what they should look forward to but I don't know of any that has come to a decision in this area.

Dr. Brown -

I think the key point here is to distinguish between a family planning policy, which is what we're talking about, and a population policy designed to look at the overall needs and growth of population in relation to economic and social factors. There have been some countries that have done a lot of work in this direction, but that is not to say they have fixed an optimum population saying that they will achieve x million in a certain number of years and then stop. But there are countries that have done a great deal of work. For instance, in the U.S.A.,a National Commission on the Population has just submitted an interim report. It has examined not only family planning but also immigration

policy, labour policy, population distribution throughout the country, urban-rural factors and many other factors that enter into consideration of the population. My personal feeling is that we should, fairly soon, be starting to look at these things. That is not to say that we are going to come up with something clearcut in the near future but I think these are elements that should start to be examined in relation to the family planning policy we're talking about now.

Dr. Campbell -

I would like to set the record straight on the question of research on prosthoglandins because I think we may have left the impression that the federal government was just sitting back waiting for things to happen. There is, in fact, some work being done in Montreal by Dr. Kinch which is sponsored by the Food and Drug Directorate and which is designed to determine certain aspects and ways in which the prosthoglandins can be used. So that there is, in fact, federally-sponsored research going on in this area at the moment.

Mr. Strehler -

I wish to add something, Mr. Chairman, to what Dr. Brown said. I believe there are other countries such as Egypt and Mainland China using economic measures in an attempt to suppress the growth of their population. To go back also to what Dr. Brown said earlier, I think it is premature for us to be discussing this in a country where we have not yet got around to delivering family planning as a basic human right to our citizens.

Mr. Bethune -

I would like to clear the research question further. Getting away from methods of contraception, is anybody in the country doing any research on motivation techniques, or are we going to be carrying out any?

Dr. Kelly -

I know that some work is being done under a Welfare Grant by Dr. Mongeau in Montreal.

Dr. MacKenzie -

We are just completing a three-year study under a federal grant which has a high element of motivational data in it on various socio-economic groups in the society. We hope to be reporting on that within the next three or four months.

Dr. Watkinson -

If there is nothing else, we can now turn to the proposed objectives. As with any program, it is desirable to have stated objectives so that, from time to time, you can refer back and refresh your memory about what it is that you are attempting to achieve. It can also assist individuals concerned with developing the various components of the program.

Prior to the ad hoc meeting, that is, the meeting held with various professional and voluntary agencies and individuals in early February, we had developed these objectives within the department. I would like to say that we hope the provinces, both on the health and welfare sides, will feel free to use these objectives in any way that suits their own purposes. I know that you have not yet had a chance to review these objectives. However, if anybody spots anything at the moment on which they would like to comment, please do so. You might like to think about them today or to look at them this evening. Are there comments from anyone at the moment on these proposed objectives?

Dr. Splane -

Dr. Watkinson, when I look at these objectives under the headings that are presented - "Suggested Objectives for the Family Planning Program" - and then look at one or two of them, notably number five, it is obvious that the title should be "Suggested Departmental Objectives" - meaning that they are the objectives of a federal-provincial meeting, that is, federal-provincial objectives. They would have to be stated somewhat differently, particularly number five. Obviously at the time we drafted them we had to think in departmental terms. Perhaps after this meeting we will be able to move beyond a departmental viewpoint to a statement of objectives which this federal - provincial group could agree upon.

Dr. Watkinson -

Thank you. I agree. I would like to stress number two. There is one matter evident from the ad hoc meeting and that is that we do need to ensure the provision of training opportunities as quickly as we can, not only for professionals but for others concerned with family life programs. To the extent that we are both involved, we ought to be examining this question together at this present meeting.

Mr. Huesing -

In the Northwest Territories, as you know, a very large segment of our population is of an indigenous nature and when Dr. Lennox spoke about methods he mentioned that the most effective method is, of course, the pill. Along with the use of something like the pill there is a period of training or a method of life style to which most of us from the "southern culture" are accustomed, i.e., we do things on a routine basis. In our case we are dealing with people whose life style is not suited in that way - the matter of taking a pill or anything else, for that matter, on a routine basis, is not something which comes as easily as it does to us. I am wondering if any of the other provincial delegates share my concern about research into more easily adaptable means of birth-control.

Dr. Watkinson -

Thank you Mr. Huesing. Don't you run into the same kind of problem, Dr. Brown?

Dr. Brown -

Yes, very much so and this is one reason why the uterine device has been used on a very wide scale in less developed countries where the same problems of motivation, of high level of illiteracy and additional social patterns make the use of the pill more difficult. I think experience in these other countries indicates that there is no one method that is really suitable. The pill has been used and the one difficulty with the pill is that it requires very good health services that can ensure follow-up. This becomes very difficult in rural areas and in areas such as the Northwest Territories where there are tremendous distances and separation of the population. There is no simple answer to this. The intra-uterine device can be considered as being a more suitable method because it requires a single period of motivation at the time of insertion but even this method requires follow-up and is not ideal.

Mr. Burns -

Mr. Chairman, was any thought given to any research on the social and moral implications of a nation-wide family planning program? I'm in favour of family planning but I do feel that many things we do have ramifications and implications that we do not necessarily see or understand or anticipate. I was wondering in number three of the stated objectives, if there is, or could there be, some thought given to this type of research or study?

Dr. Watkinson -

Well, that is a tough one, I'll be glad if anybody will volunteer an answer.

Dr. Lennox -

I refer to the types of research we have to be able to stimulate - to promote interest in certain areas of research in family planning. If we were to undertake or to promote contract research we would have more positive control as to what subject material we were interested in developing and what answers we were looking for. We anticipate that an informational and educational program, and the resultant discussions into the ramifications of family planning will, either directly or indirectly, stimulate interest of the behaviour of social scientists in some of the areas of motivational, attitudinal, moral, ethical components of the whole program. This will require time, maybe one or more years to develop this attitude towards family planning and particularly raise the level of consciousness of research workers that this would be an interesting thing to study.

Dr. Watkinson -

Thank you. Does anyone else know of any work that is going on with regard to the social and moral aspects?

Dr. Campbell -

Dr. Mongeau will have something to say about this when he arrives. At the ad hoc meeting he made a strong point of this particular aspect of the subject. That is, we were considering not only contraceptive methods in family planning but were also considering all aspects of the family. I was most impressed by his view that one must look at all scientific questions. It is not purely a question of contraception.

Dr. Brown -

Just one note on the moral issue - I think there was a great deal of discussion prior to the passage of legislation in 1969. There were briefs submitted by various religious groups in Canada by various voluntary agencies, statements by various professional groups and so on and I think that at the time the question was examined quite adequately. These organizations and persons went before the Parliamentary Committee considering the legislation on the amendment of the Criminal Code and they did get at some of these questions. Dr. Lennox, did you mention the fact that, in addition to Dr. Mongeau's study on the social question, there was a previous study in Metropolitan Toronto by the Department of Sociology of the University of Western Ontario?

This was in 1968 to examine the attitudes, knowledge and practices of Canadian couples in matters relating to family planning. This study is still in the process of analysis and it might well be considered necessary for other parts of the country as well.

Dr. Watkinson -

Has there been any interim report?

Dr. Brown -

Yes, there have been a couple of reports - a couple of papers published from it - but the full-scale report is not yet complete. There is also an interim report of Dr. Mongeau's study, which is similar.

Mr. Cornish -

Mr. Chairman, I just wanted to clarify whether our concept, as related to objectives of family planning, includes the birth of the first child, particularly the child born before marriage? Are we thinking along these lines or are we talking about the ultimate size of families? It is of particular concern because I think the child born before marriage sets up, in many cases, a whole cycle of processes which can lead to many social problems beyond that point. I think it is important to consider it from this point of view as well.

Dr. Splane -

In response to Mr. Cornish's comment, I would certainly think that the term "family planning" might suggest, in itself, the family within marriage. I think, however, that if we look at our Minister's statement and the Parliamentary discussions, as well as the recommendations on the status of women in Canada, there is evidence that family planning is regarded as going beyond the legitimate, the structured family. The reference I made to child welfare and the concern about this problem is indicative that we, on the welfare side, certainly think of family planning in connection with the need for information and material to extend to all who have a need to prevent unwanted pregnancies.

Dr. Lennox -

Mr. Chairman, my remarks will just relate in part to what Dr. Splane mentioned, in that the concept in family planning is that the children are planned for and will, therefore, be wanted children. In this respect the first pregnancy, if wanted, would fit into the realm of family planning. This would depend on the individual personal choice as to whether or not they wish to utilize methods that would prevent the development of pregnancy

or whether or not they, for their first baby, were hoping to have a pregnancy. So it would depend on the wantedness of such child. This would reflect the social situation of singleness or marriage and I think this is a round-about way of answering the question.

Mr. Knight -

Provincial departments of welfare and other child protection agencies are inevitably concerned with the problems arising from pregnancy out of wedlock and the needs of the unmarried mother. I'm not familiar with any work which has been done in Canada, but research in the United States has indicated that the unmarried mother is in medical terms, a person at risk. It has been found that unless she is given skilled, intensive care, a girl who has had one child out of wedlock is likely to have more. On the other hand, some experiments in the United States have shown dramatic success with intensive programs of social rehabilitation for unmarried mothers, including information about family planning. From a child welfare point of view and in relation to the prevention of illegitimate births, we would be very much concerned with this type of situation.

Mr. Bethune -

I am curious from a child welfare point of view again. We often get involved in counselling minors, young girls, in the methods of contraception. What is the legal position here?

Mr. Eric Smit -

I wish I could really answer that. There is a possibility, I imagine, of differences from one province to another in this matter. Otherwise I should think there is nothing illegal about talking about contraceptive methods with people. However, if you actually prescribe a pill or insert an I.U.D. in a case of a minor without parental consent, I would think there might be a problem. Of course, if you are dealing with wards of the child welfare authority I assume that acts in loco parentis and therefore gives permission. However, I would really suggest that the proper person in your province to ask about this matter is your legal advisor because this, I think, is a straight legal question which I would not want to be caught saying go and do this and then have it turn out that you got into trouble. Sorry, I can't be more definite. I might add that if this issue had earlier come up in a number of places, presumably it would have caught the attention of the research team that worked with the Royal Commission on the Status of Women which does concern itself with the question of the criminal laws that affect the work of medical practitioners. One of its recommendations is that the criminal law be clarified so that sterilization performed by a qualified medical practitioner, at the request of his patient, would not engage the criminal

responsibility of the practitioners. It goes on to recommend that the provinces and territories adopt legislation to authorize medical practitioners to perform non-therapeutic sterilizations at the request of the patient, free from any civil liability toward the patient or the spouse except liability for negligence. This is on a different issue, of course, but the fact that it was looked at would suggest that the point you raise has not previously come up. Perhaps you have, however, encountered parental or community criticisms of this that would lead you to believe that there might be a ....

Mr. Bethune -

The thing we're concerned about is that we want to involve our school guidance people into actively talking family planning at the school level. We are finding that a pretty high percentage of our unwed mothers come from our own wards so we are going to be involved in the business of possibly counselling our own wards as you suggest. In addition, many of our public health nurses tell me that when they go to the schools they are getting requests from 13, 14 year old girls. They have to do something. They have to decide what to do and at this point we are inclined to think the criminal code might limit us in some ways. Are we contributing to juvenile delinquency or something?

Dr. Khazen -

I don't know about welfare rules but from the medical point of view, I think the age limit is sixteen and any doctor would feel he could treat a patient in any way, even to giving a contraceptive without parental consent. For the province of Ontario there is presently legislation before the House, trying to lower the age of treatment, specifically for V.D., from sixteen to twelve, without parental consent. Of course, for the protection of the doctor, if she is under sixteen and he has to put her on an oral contraceptive, he should probably secure parental consent because of possible side effects. But in some family planning clinics in health units they are using the age of sixteen as their cut-off point for treatment - if you want to call it treatment - without parental consent.

Mr. Eric Smit -

Yes, it has struck me in listening that this evidently is a matter of real concern to the provinces. Since it does relate to federal law of the Criminal Code, it might be a useful contribution for us to look into this matter and make some recommendations or comment about it that would be helpful in the provinces.

Mr. Bethune -

That would be most appreciated by Saskatchewan.

Mr. Palko -

In regard to Mr. Bethune's question, the Metropolitan Toronto Board of Education has just started a program of contraceptive education without any recourse to parents so they really are in the field. London Board of Education is in the process of doing the same thing and I think probably as the details become available I could give you the references.

Dr. Khazen -

I was going to mention that at present it is in the curriculum to teach family life education and information on contraceptives. The teachers are not allowed, and Public Health Nurses are not allowed, to do so. A month ago, the city of Toronto, the Board of Education, approved the open teaching of contraceptives and in this manner you do not need parental consent to give the information and as you were saying, the city of London is considering this.

Dr. Banister -

I feel that we should reassure people somewhat on this basis because I know that, certainly in the Childrens Aid Society area, we are prescribing oral and intramuscular contraceptives towards. I think it is unlikely that there would be any kick-back on this subject. If one expects to modify the Criminal Code, for example, there might be tremendous delay involved and I think that it would be unfortunate if people waited for full legal clearance because it is difficult to get.

Dr. Watkinson -

Yes, I would agree. Perhaps we could flag this as one of the matters to be looked into further. Meanwhile, I am sure that those in the provinces involved in any of these activities will not hesitate to consult with their own legal authorities, to the extent that guidance may be required.

Mr. Strehler -

Yes, Mr. Chairman, I had occasion recently to investigate the problem of contraceptives in minors. There would appear to be nothing in the federal Criminal Code which says "Thou shalt not give contraceptives to minors". The particular hangup seems to vary from province to province. A good example of that is, I think, B.C. where the age of consent is sixteen but where one cannot give contraceptives to minors or to people under nineteen without the permission of the parents. So, it would appear to be province by province.

Dr. MacKenzie -

I would like to comment that we have been doing this

since about 1964. The Attorney General of the province has stated a variety of things. One, that treatment is not involved if foams, barrier techniques and so on which are available across the counter are used. Secondly, it seems that a rather lenient view is taken if the information etc. is given by a responsible agency and with due consideration, counselling, etc. I don't recall any instance where we have gone below the age of fourteen but we have a few-not many-fourteen and fifteen year olds. It is very simple with the nineteen year olds because they are adult persons and this has made our life a little easier.

Dr. Watkinson -

Thank you, Dr. MacKenzie. This is a very important subject and I am hoping that some of the things that are being said will be of use to you.

Dr. Khazen -

One more comment. I was surprised to hear that the Criminal Code has to enter into it specifically. Mostly it is what the doctor feels. If he feels he would like to treat the girl, give her contraceptives, he can do it without parental consent. It is the medical society that usually have by-laws. You would not find in the Criminal Code that there is an age limit to treat or not to treat.

Mr. Van Der Veen -

I think that we, in our future work in relation to this, should take particular care to interpret the legal aspects because that is just half the problem. I think that in some provinces and areas, the prerogative of education being a provincially-controlled responsibility, it would probably take precedence.

Dr. Watkinson -

For the moment, could we conclude by suggesting that on our part, federally, we'll look into this - that is, try to find out what is the application of the law in a federal sense. I have no doubt that you in turn, with regard to your own particular province, will do the same.

Mr. Archibald -

May I reflect on a comment I believe Dr. MacKenzie made in relation to family planning. Is it primarily concerned with contraceptives? I am committed totally and think our government is towards the concept of a total care package where services are available, or in which at least the people who are involved in a clinic are aware of the other matters that go along with people that do attend family planning. If that is what we mean, that is perhaps an addition that should be put into

the objectives. I would recommend that family planning be viewed on a broader scale than just the limited passing out of contraceptive information.

Dr. Lennox -

In reference to the scale of family planning, the use of contraceptives is an important but fragmentary part of the program and the education. Information and education are vital parts of the program. But all the aspects of the social situation within which a family is living and the various factors such as physical, emotional, social and health, are integral parts of the program, with the contraceptive as the way of doing it. Full explanations as to the reasons for the use of the contraceptive agent, the proper use, information as to the potential complications in its use and follow-up of the patient, these are all implicit in the term, so that the use of the contraceptive agent in family planning is just a segment of a total program.

Mr. Knight -

Mr. Chairman, as our friends from the North have pointed out, family planning is not simply a matter of prescription, it is a matter of life-style. Anything that affects life-style is relevant. Those of us on the welfare side would certainly see the prescription of a particular method of contraception as one particular point in a process which may involve a variety of situations. When you're working with a family, for example, you begin often with other problems that lead eventually into considering a method of family planning.

Mr. Gaudet -

Just one comment along that line. I think that one thing we should be aware of, and concerned with, especially in the educational area, is the education of the male and maybe also do more research on male contraceptives. I feel that the males have less taboo re sex than perhaps do females, and I wonder if there is not a dynamic here that could be explored with the young male.

Dr. Watkinson -

Are we ready to pass onto item three on our agenda - the education and information program in family planning? The purpose of putting this on the agenda at this point is to begin sharing with you some of the planning and some of the implementation of certain items mutually agreed upon at our ad hoc meeting of last February. You will begin, I think, to get some idea of the things we've been active with in the past few weeks with a view to making these resources available to you as appropriate.

Mr. Palko -

Thank you, Mr. Chairman. I am pleased to share with you some of my observations which may have some relevance to the information - education component of the family planning program. In the next few minutes or so I would like to review here the potential target audiences which we feel and you may feel, too, should be of primary concern, the audiences to which we should direct our efforts. Also I wish to point out our accomplishments to date in the assessments and evaluation of education and information materials in family planning. I think in addition, I will ask you, as a favour, before you leave or probably shortly after you get home, to sit down and think about the education-information component of this program and share your views with us. I have prepared a short one-page questionnaire in which we ask you, if you can think of a type of a publication, a type of material, a type of audio-visual aid, or a type of film, which this department or somebody else might produce in the future and with what aim in mind? I hope you will assist us in this regard either within these two days or upon your return home.

In view of the suggested objectives which we have just finished discussing I think you will agree that there is no one agency to-day in Canada which could really undertake alone a program to meet the objectives of such magnitude. I think the reasons for this are obvious, in that, involved in the process of education and information at the present time, there are a number of voluntary help agencies, a number of institutions of higher learning, a number of departments of health, departments of welfare and others. Furthermore, physicians, nurses and social workers already provide this type of information to the client. I would like to begin by referring to some of the target audiences which we feel should be identified at this early stage of this program if success is to be ensured. I hope that you, too, might have thought of other target audiences and that you will be able to suggest them. Our communication experts in the field of family planning say there are usually two types of audiences in the priorities which they consider important in a nation-wide program of family planning. First of these groups are the professionals. This includes the whole spectrum of professional help such as physicians, nurses, social workers, media specialists, teachers and students in special schools of medicine, nursing, social work and so on. The second group is the lay group including adults in the child-bearing age, which is usually somewhere between 15 and 45, high risk mothers and high school and university students. In some instances it is suggested that a third group should be considered, namely, the opinion makers, the opinion leaders and the leaders in governments. I think dissemination of information on family planning to individuals in the profess-ional groups is considered, usually, the essential first step in the planning of an educational program. It is reasoned that the members of the general public turn to the professional group for

advice and, in turn, are able, in a sense, to influence, to motivate, people to some desirable action. There is, I think, advantage to this approach if you look at it from the point of view of the Department and from the point of view of a new program in that, while the professional candidates are being prepared, trained and so on, you have time to develop Canadian materials which are applicable to the Canadian situation. I'm saying this quite openly because if you look at the Canadian field of educational information materials and audio-visual aids today, with the exception of one booklet, we simply have not developed anything of this sort which has a Canadian content applicable to Canadian conditions and circumstances. I would not like to leave you with the impression, of course, that in the early stages of developments that we should really go and educate the professions. I'm merely saying that, arising out of our experience in the smoking and health program, we should approach the two groups simultaneously. This would probably be desirable at this stage. In family education programs elsewhere, it has been demonstrated that encouraging development and holding institutes, workshops, and seminars in family planning, regionally, provincially or locally, is something which usually pays good dividends in terms of preparing a group of professionally trained people as the family life educators. I think that it is in this early stage that we should try to encourage professionals to become, so to speak, the evangelists, the spreaders of the bible in family planning. With regard to educational information again, I am sure you will agree that it is clearly impossible to mount a single effective and persuasive program that would likely change the attitudes of our audience to a significant degree or would modify their behaviour. I think in the long run it is suggested that the broadside approach through the mass media will bear some fruit if done on a plan, if done on a systematic basis and directed to specific audiences rather than in a shot-gun manner - here a shot, there a shot. Thus, I think, we will have to consider other devices in addition to some of the educational and information materials of which you will be hearing a great deal. For instance, how do we reach people through counselling? How do we get people to the workshops and institutes? Who should be doing these things? These are, I think, some of the questions on which I would like to hear comments from you.

In so far as our own departmental role is concerned, in the area of providing information - education to Canadians, we feel that we have a definite mandate in the Health and Welfare Act to provide such information in co-operation with the voluntary agencies, provincial departments of health and welfare and others. It is to this end that we have recently completed a review of existing educational and information materials and have selected those which we felt had some relevance to Canadian situations. The publications you see displayed in the far corner are some of the publications which we have reviewed. You will note some are marked with stars. These are the publications which the

communication experts and the professional people in the Department felt would be suitable for Canadian use. Here again we would appreciate your counsel and if you know of good materials, we would like you to bring them to our attention. I think I should mention to you what we have been reviewing and what we have done to date - the publications we have looked at and the criteria which we have employed. Basically, in assessing the publications we have looked for information for doctors, nurses and social workers as one category of professional workers. The second group of people we considered was the general public and here we have differentiated between the low and middle income groups. Thirdly, we have examined information which would be suitable for teachers and students. Mr. Price of Information Services will be discussing the production of information and educational materials in family planning. He will give you some idea as to the type of material we anticipate having for use by the provinces in the future and what we have, so to speak, scrounged at this point and are available immediately. For my part, I would like to again prevail upon you to help us determine the Canadian type of publications we will be looking for during the next fiscal year and developing materials for use by Canadian audiences. In regard to this form, I would very much appreciate your taking time either while you're here or upon your return home and after consulting with your own people in the field of education, your health educators and others, to let us know just how you feel about the whole subject. To conclude, I would like to draw your attention to two mimeographed papers which the Health Education Unit has prepared. These provide sources of educational materials in family planning which you might find useful, the addresses where some of the publications can be obtained as well as the sources of films and films strips which are in current use in Canada.

Mr. Price -

Mr. Chairman, Ladies and Gentlemen: - the number one objective of the family planning program which you have in front of you concerns public information. The information program at the moment is following two main approaches. First, to inform people of the availability of family planning consultation in their community and secondly to provide doctors and other counsellors with educational aids. I want to stress the word aids ; we believe that family planning services should be on a face to face basis, either individually or in small groups. Books and films cannot do the job for us but they can be a tremendous help if used properly. We recognize that family planning programs, to be effective, must be directed by the health and welfare departments of the provinces in co-ordination with the health and welfare professions. Some of you are already quite well equipped with films, booklets and so on, some of you are not. In front of you is a list of informational and educational materials which we in the federal department are ready to provide to support the program in your province. The items listed here can be sent to you in limited quantities at no charge. You can have the three films, for example, on

extended loan from our department for your own provincial film libraries. Other sources are listed on the sheet. The medical handbook is available through the federal department. The booklets listed here are up-to-date and adaptable to Canadian needs, as Mr. Palko has mentioned. The exhibit mentioned on the sheet will be unveiled at the Canadian Public Health Association meeting in Toronto next month and we shall do our best to respond to requests for the use of the exhibit in any province. We are, of course, concerned with providing aids that will meet our particular needs in Canada, and in both our languages. At the foot of the third page, you will find an outline of the materials that we propose to produce in the months ahead. It is not an exhaustive list, and we shall welcome your suggestions on these and other possible items.

I can give you an idea of the film we are engaged in producing through the National Film Board. The requirements for the film, as drafted, read in part as follows: A general audience film, 20-30 minutes, intended to promote public interest in family planning, particularly among persons of 15-45. It might also be used in the schools under appropriate direction. It is important to use terms and imagery that will be readily understood by disadvantaged persons with limited education and isolated social life. The film will deal with human reproduction and contraception but not in extended detail. This information is available in other films. It will draw attention to the reasons for a family planning program in Canada in relation to both health and social welfare. The program aims to reduce infant mortality and the incidence of unwanted children, child neglect, abandonment, desertion, welfare dependency and child abuse. These points will be stressed in the film. Family planning methods will be introduced, placing the question of participation before the individual and stressing the freedom of choice. The film will encourage those interested to seek advice from the physician or family planning agencies.

I would like to emphasize our concern with avoiding a middle-class approach to a question which concerns mainly those elements of our population having very limited education. Hence our strong emphasis on the visual - on films, television, posters. In our television clips, we plan a closing message which will refer the interested viewer to his doctor or to family planning services in his community, giving the name and address of each such service. If you wish these clips for use by television stations in your province, we shall require a list of the addresses from you and we shall be in touch with you on these and related matters.

Je veux adresser quelque mots à mes collègues de langue française. C'est évident que nous n'avons pas assez de films et de livrets en français. J'espère que vous pourrez nous faire d'autres suggestions tirées de votre expérience. Nous sommes

très conscients de notre responsibilité quant à la distribution de renseignements sur le planning familial à tous ceux qui les requièreront, et ce dans les deux langues. Nous sommes prêts à travailler en collaboration avec les gouvernements provinciaux et des organismes d'intérêt privé.

In closing I want to say that we are very dependent on your comments and suggestions for these information aspects. Please do not hesitate to share your ideas with us. Thank you.

Dr. Watkinson -

Thank you Mr. Price.

I think you can now see what it is we're beginning to work at, but, of course we are dealing with only one segment of the program, that is, public information, and these things take time. We are much indebted to both Mr. Palko and Mr. Price for the effort and the rapidity with which they have moved ahead in this particular area. They have only had a matter of weeks, but this part of the program seems to be developing most satisfactorily. You just began to mention, Mr. Price, the requirement to meet the needs of those in the low economic segment of our population. You talked about visual needs and I would stress again, that this is a matter that came out clearly in our meeting of early February with the ad hoc group. There were a number of criticisms that existing programs, and perhaps plans for programs, were aimed at those in the higher social economic groups of the country whereas the real needs may be at the lowest level. Those without adequate education or those who do not have access to information through the conventional channels must be reached by some method. Suggestions for getting to those groups will be very useful for our purposes and perhaps for your own as well.

Mr. Bethune -

I noticed in these films and all your plans that you do not seem to be producing anything aimed at the counsellor himself. You aim either at the consumer or the doctor or the nurse, on technical matters of contraception. There seems to be nothing directed to the worker who is facing a client across the table trying to motivate him to plan the size of his family, trying to counter some of the arguments that people use as to why they have large families, or why they don't plan. I can think of things in Saskatchewan, particularly, that we have always run into like, "Why plan our families in Saskatchewan - we're already losing population. You know we have these vast untapped resources here - we need population," We need something that can answer these questions, that is aimed specifically at the counsellor. This seems to be our biggest need, not something to get to the consumer of these.

Dr. Watkinson -

What kind of a counsellor are you talking about?

Mr. Bethune -

It could be a public health nurse, a social worker or the worker who acts as the school guiding counsellor trying to motivate a previously unmotivated family to plan the size of the family. He's not trying to tell them how or anything like that. He'll send them to a doctor to find that out.

Mr. Palko -

You mean, leave those guides for a connoisseur who can get some information on family planning and then pass it on to people of his own background.

Mr. Bethune -

Yes, I remember working for a family planning federation in Canada here and they sent out a document on a list of high fertility motives and an international list of low fertility motives. They were very useful. I hope every one of our workers will memorize them because they should cover just about every question that they will have to face. We can't, presumably, assume that it's just the people with families that want to motivate; it is also our own staff that we have to motivate, to get them comfortable doing this.

Mr. Palko -

If I have not expressed and if Mr. Price has not expressed this, be assured that we have had in mind just this type of a thing but it will really be a handbook for the counsellor, a handbook for the social worker, a handbook for the public nurse, which will give them some of the help. You are aiming at some kind of a position paper-this is where we stand with regard to family planning-this is what the Canadian needs are - is what you know you can do - other choices - these are the resources, so that you, as a counsellor, can provide this information or pass it on to the client or the consumer. A good example - there are two - you will notice - two publications by the same author, "A Guide to Family Planning for the Social Worker" and "A Guide to Family Planning for the Public Health Nurse." This is the type of general information, Mr. Bethune, you should get.

Dr. Watkinson -

Can I say at this point that I think this is a very useful contribution. This again was something that was well brought out at the ad hoc meeting. I think Dr. Mongeau was the

one who high-lighted this because he talked about the training and the education of multipliers. Before we approach the public there is a great need for providing rational arguments that can be used and which can be persuasive in themselves. This will help the middle person - both motivating that individual and also providing him with what he needs to tell the story effectively and persuasively. This we should earmark very clearly. It is not just the provision of handbooks with technical information; it is something more than that.

Mr. Van Der Veen -

Mr. Chairman, I would like to direct a question to Mr. Price. In the development of these films and visual aids, is consideration being taken to: (1) - the language barrier of the indigenous people particularly in the North and (2) - are these communications media applicable to these indigenous people?

Mr. Price -

The answer is yes, Mr. Chairman. It is not as far advanced as we would like, but in the Yukon and Northwest Territories Medical Services of our Department is very concerned with this matter and, of course, we have a representative here to-day from that Branch. Dr. Frost, in particular, has been very active in working with us. We are conscious of the need -(a) for materials that will meet the particular needs of the people and we have quite a bit of experience in this field through our Medical Services and (b) the matter of the indigenous languages for which we have quite specific plans.

Mr. Cornish -

Mr.Chairman, with respect to the matter of using or having materials that are suitable for indigenous people. I am thinking in terms of indigenous people with specific language problems as well as people who live in low-income communities. I think we are beginning to learn, in the social services delivery system field, that some of the more popular ways of delivering service is through indigenous people themselves. I'm just wondering if, in the preparation of materials for dissemination to the public, consideration is being given as to how you might prepare materials that could be used by neighbourhood people - volunteers or perhaps even paid local people would be trained to use this information and would get it to their neighbours and to the general community. I think you might even consider the fact that gaining male support for all kinds of family planning programs is, perhaps, going to be one of the more difficult areas.

I was wondering if using some kind of male community

development worker - "community development" is the loose use of the word - in communities for getting information and support from local men might be another approach.

Mr. Palko -

If I may, I think your suggestion for the publication of some kind of manual for indigenous workers is a "must". Medical Services, as you probably know, has developed a type of health worker who is recruited either from the Indian or the Eskimo population for work in the field. Of course, the type of a publication, manual, or information for him would be slightly different from that for the ordinary white. This is an excellent point you have raised, that we should be directing our efforts to the indigenous people not only in the health field but also in the welfare field. I think with respect to publications directed to male workers, we will have to reach the male eventually too and not leave the burden on the female.

Mr. Cornish -

May I just clarify, Mr. Chairman. You are probably including this, but when I spoke of indigenous people, I was talking in terms not only of Northern communities but also downtown urban communities.

Mr. Gaudet -

Just two observations. One of them is that I would emphasize Mr. Bethune's point concerning training material. I would recommend exploring something along the area of a comprehensive training kit. I'm talking about reaching attitudes, giving knowledge about techniques or whatever. My second point, and this might not be a very popular observation, but it is well intended, I think in some areas, particularly in New Brunswick where we have isolated communities, an important area is the medical profession itself - medical doctors who do not have in-depth knowledge of family planning techniques. I have talked to people about some very capable gynaecologists who feel secure about talking about inserting various devices, or something in the more sophisticated area of family planning than the pill. I wonder if the medical profession here could not have any pertinent contribution to make, especially in reaching some of the isolated communities where doctors do not necessarily have the availability of in-service training on a continued basis.

Dr. Watkinson -

Thank you, Mr. Gaudet. I might say that we have had discussions with the Canadian Medical Association with respect to the needs of physicians. There is ready acceptance of the fact that many physicians would welcome opportunities for some kind of a refresher course, short in duration, or the provision of material that could be placed in their hands to assist in an

understanding of accepted current methods. This is the reason, in part, why we are proposing, through the assistance of the Canadian Family Planning Federation and the International Planned Parenthood Federation, to send each physician a copy of the medical handbook that was mentioned by Mr. Price. We recognize that it is only one of many things that can be done. We have also met with the Association of Canadian Medical Colleges with regard to the present curricula of medical facilities.

Mr. Huesing -

In regards to reaching people, through television or other types of broadcasting media, it seems that it is generally directed to "here what's available - go see your doctor or go see your public health people." I think we have to stress the fantastic difference between the situation we have in the North-west Territories, perhaps even more than in the Yukon, and where the population is generally concentrated in larger population centres. In the Territories, for example, we have some ninety-odd communities of which fifty or so do not have more than 100 or 120 people. Those communities are where we have our greatest family planning problems. Doctors and public health nurses come up for more than a year. There is little personal contact between the people and the professionals who dispense these services. This is just by way of comment. I have no solution. Perhaps someone else does. The other comment I have to make is with regard to films; unlike Mr. Bethune, I heartily approve of these because, as Mr. Van Der Veen mentioned, Canada has a bilingual problem. We have a - I don't know what you would call it when you have about 12 working languages ranging from Eskimo to various types of Indian dialects. Generally speaking, the types of films which seem to be indicated here are those which will reach people who have only a minimal understanding of the English or the French language.

Dr. Watkinson -

Would you like to comment on this, Miss Nolde?

Miss Nolde -

This is a personal thought. I think the philosophy of the needy people has to be considered. To many, a large family is their ultimate happiness. They don't see it as a problem to have a large family. Therefore their whole philosophy will have to be changed in their approach to family planning.

Mr. Van Der Veen -

May I suggest, further to what Miss Nolde has said, that with regard to the prevention of family crises or unwanted

children that we consider visual-aid material and this type of thing. The native people themselves, particularly through their articulate spokesmen which are now beginning to merge with groups such as the Native Indian Brotherhood, which are quite vocal and are assuming more responsibility, may react negatively to this whole suggestion. I think they should be included in planning stages. Thank you.

Mr. Bethune -

Concerning procedures, will the federal government be running any of these T.V. programs, buying time at the local T.V. station and so on, for their own ads or will they have to be worked through provincial associations?

Dr. Watkinson -

I prefer that Mr. Price answer this.

Mr. Price -

We are not, ourselves, planning any T.V. programs. We do plan to have short spot announcements to promote public knowledge of the services available but we are hoping that we can encourage programs on T.V. stations, interviews and so on, to bring out the points in the family programs which we would like to see brought to public attention. We can do some things from the federal level but I would expect far more can be done at the provincial level by provincial departments.

Mr. Bethune -

It is still not clear. Are you going to make these clips available to the provinces to be used at their discretion or will you be using them yourself?

Mr. Price -

These will be used by television stations in cooperation with provincial departments of health and welfare. In other words, we will be in touch with you before making these available to television stations in your area. I am not sure at the moment whether we will hand it to the television stations or whether you will but it will certainly be a joint effort.

May I also add that television clips are not used on a national basis. They are inserted between programs or during programs by the T.V. station.

I think there will be a credit at the bottom, not particularly for the sake of credit but, particularly, for the sake of acknowledging responsibility by the federal department and the provincial department concerned. I think we are normally

obliged to give some identification of the source of a promotional message.

Mr. Van Der Veen -

Mr. Chairman, with that approach, would you not be concerned because of BNA implications and certain political implications that you would perhaps not get the response from some provinces that you would hope for if you left it to their jurisdiction?

Dr. Watkinson -

Public health is still primarily a provincial matter and we would wish to maintain this in regard to family planning.

Mr. Palko -

Mr. Chairman, if I may elaborate. I think we are talking here about t.v. clips which would carry this message of our co-operative program directing people to the resources in their province. However, as Mr. Price pointed out, we also hope to produce t.v. clips of national significance, as we have done with smoking and health, which would stand independently. I think the confusion arises from the fact that this is a co-operative clip; but there is nothing to stop us from promoting the concept of family life or family life situations.

Mr. Price -

Perhaps I could add one further point following what Mr. Palko has said. We do not plan any great program of clips. In other words, we are planning a few because our resources are limited but we are hoping this may stimulate the provincial departments to do something on their own in this field as well.

Mr. Palko -

We feel that it is our duty to provide some kind of leadership. I think this is one area where we can provide this type of leadership to the provinces. Without trying to antagonize, it is simply talking about contraceptives and services at this point.

Mr. Price -

I think that we are hoping, too, Mr. Chairman, that private organizations like Mr. Strehler's, for example, might have his group, and Dr. Mongeau and his organization, get into this field and sponsor messages for the public.

Chairman (Dr. Lennox) -

Are there any other questions?

Il me fait plaisir de vous présenter Docteur Serge Mongeau, Directeur du Centre de Planning Familial du Québec. Nous sommes tous heureux que le docteur Mongeau ait pu participer à notre conférence. Il nous parlera d'un sujet qui l'intéresse tout particulièrement: "Le Centre de Planning familial du Québec".

Dr. Mongeau -

Le Centre de Planning familial was founded in May 1967. We have a definition of family planning which is the following: family planning, for us, is the possibility for the couple to have the number of children they want, at the moment they want, with sexual fulfillment. We work in three directions - research, education and training, and community action. We always work with people that we call multipliers. Those people are the doctors, the teachers, the nurses, social workers, priests - all those people who have access to the population. We are working directly on the population but always working through those who are working with the population. We now have five sections working in the Centre. One is family planning proper with a small experimental clinic where we will receive people for service, training and experimentation. We have sexology service where we have a clinic on sexual problems and also where sex education is done through many experiments. We have a research service which is helping the other components to render their services. We have a communication service which is working with many communities and many groups in these communities in many cities of the province of Quebec. We have around 15 different cities that have groups like this studying what are the needs of their communities and what could be done to answer these needs. For all these cities we are now completing a series of lectures that started three years ago. These were given with the help of the Provincial Government Department of Education and we visited these different cities between five and seven times for sessions of a duration of 20 hours. So we have a full program of family planning that was given to them between 100 and 120 hours on all the aspects of family planning, demography, moral aspects, technical aspects, how to start and to run a clinic, sexual problems in relation with family planning, etc. Finally, we have an international section that started last year where we are receiving people from underdeveloped countries, French speaking underdeveloped countries, who come to Montreal where they have intensive sessions on family planning on both the theoretical practical aspects. Our international section is also working with the International Agency in Canada to develop research programs in a few countries. All this is financed by different funds. This year we have received, up to now, a little bit more than $150,000.00 from the Provincial Government and more than $45,000.00 from the Federal Government for research we did. Finally, for the international section we received $115,000.00 from the Ford Foundation and the Population Council last year. This year this will be paid by CIDA in Canada.

Although we have been active for three years, we are not fully satisfied with our actions. Now, everything that we have been doing is put in question. We are trying to make more long-term plans which will lead us to three types of action or three levels asking the government to establish or to state, very clearly, a population policy which would comprise a family planning policy. It is very important to make a distinction between the two concepts. We think that even with a province like Quebec, it could be a good thing to have a population policy. To have more children we must try to have a family planning program. Family planning aims to meet individual needs and a population policy is a way to try to promote a policy for a whole population which is very different.

We will also work harder. We have been doing this for many years but more with the professional or services level. We want these people to try to study, more and more, the kind of services that are necessary for all segments of our population. We have the impression that, at the moment, most of the services are middle-class oriented. If we want to reach the poor sections of population we must make many changes in our services or implement new services. A problem of our province, I think of all the provinces, is also the rural population. In the cities people have fewer problems obtaining good services, but outside of the big cities many problems call for a different kind of solution. Finally, we are orienting our actions to the populations so that they will ask for good services and will participate in the building of these services. Here again, in many instances, we are building services for the poor classes without their advice and we are building things that are not really what they need.

I would like to return to the research part of our program. One project, nearly completed, was a three-year study on the poor classes of the urban areas of different cities of the province of Quebec. This is a long-term project to determine what the people want, whether they want children, if not, why, whether they need services and what kind. We also have a study under way on abortion - illegal abortion - to see what are the consequences of these abortions, the psychological consequences. One thing distinctive of our Centre is the preoccupation of the psycho-social aspects of family planning. We have never undertaken research on the biological effects of this technique but have tried to ascertain the psychological and social effects of sterilization, of any kind of techniques, as well as the kind of approach necessary to reach the people who need more family planning. This is, in a few words, what we are doing and I think it would be more useful if you were to ask questions and I would try to answer them.

Speaker -

Doctor, do you utilize volunteers in your program?

Dr. Mongeau -

No, we have a multi-disciplinary team which is comprised of one demographer, one anthropologist, two sociologists, two psychologists, one social worker, two social assistants, one gynaecologist, one nurse, one sexologist, one community organizer, one social animator, and a few secretaries.

Speaker -

When you were speaking of reaching groups that are not now seeking out the service or to whom you are expanding the service, I think you used the word "poor groups." Can you see the role of using what we call lay people?

Dr. Mongeau -

Yes, we are not directly giving services to the population. We are working with what I call "multipliers" and among these multipliers we find many lay persons. Outside of Montreal there are groups, family groups, taking part in the planning of what we will do in this city so we utilize members of family organizations, teachers, priests and all these. They are working together and we encourage them to use voluntary organizations. What we see as a scheme now that is growing more and more is voluntary groups undertaking the education and information part and professional groups, like hospitals or social work agencies, undertaking the service part. This is what seems to me to be the scheme which will be adopted in the province.

Chairman (Dr. Lennox) -

Thank you. You will recognize that Dr. Mongeau and his program in Quebec have made tremendous progress in delivering family planning services to the population groups. Dr. Mongeau and his group have tremendous experience at the local level in the delivery of services of this type to the people. Are there further questions?

Dr. Mongeau -

I would like to make a small correction. I feel we have no great experience in the delivery of services because we have not done all that much, because we are not satisfied, and because there are so few services given outside of Montreal. I think, however, we are working on a middle-term way. I think that very soon it will be possible to open services throughout the province because we did not ignore any part of the province. We went from Gaspé to Val d'Or with the result that all the province is covered now with people who followed our lectures and who are quite conscious of all aspects of family planning. We worked, I would say, on the infra-

structure of the province and now it is ready for services. However, up to now, no big results were obtained.

Chairman (Dr. Lennox) -

I would like to ask Dr. Mongeau about the use he makes of the community organizer and social animator, especially the latter. If you are not dealing directly with the public at this point, Dr. Mongeau, are these two persons working with other community organizers and social planners to indicate the area in which they can directly involve the public or what is their role?

Dr. Mongeau -

The social animator works with the groups already formed or helps to form such groups so that they will supervise the culinary of such services. He also makes known our concern with the poor sections of the city and he tries to include such groups in the planning of delivery of services. In community organization we are Le Centre du Planning familial du Québec so we try to rationalize our actions. We try to choose actions having the biggest impact so that if we for instance have a press release, it is because we think it will have this impact. We try to anticipate the effect of our action.

Speaker -

You mentioned that you are going to undertake research in the biological effects.

Chairman (Dr. Lennox) -

No, social.

Dr. Mongeau -

I indicated that this was an aspect that we shall leave to the hospitals equipped to do this. I indicated that we did not undertake such research. We are doing research on the psychological and social aspects of family planning.

Speaker -

Perhaps I misunderstood. You are not planning that then.

Dr. Mongeau -

No.

Chairman (Dr. Lennox) -

Are there any other questions that come to mind?

Speaker -

Just let me clarify that you did say you visualized your organization delivering services; anything that you do is directed towards getting government or private agencies or others to deliver the service.

Dr. Mongeau -

Exactly. We think that a province does not need two services like this. I think it is nearly para-governmental and what we are doing could be a governmental service. This is something you don't have to multiplicate in the province because research will reveal many things that will apply to the whole province. The kind of other services that will be given will be oriented toward the client, not like our services oriented toward the multipliers or the others -- is it clear?

Chairman (Dr. Lennox) -

I don't understand why you would want the government to come up with a clear policy statement on a population policy. Why not? I'm not quite sure of the difference between the two, but why not just a statement of approval or backing for a family planning program or something like this? What's the difference?

Dr. Mongeau -

It is because the province of Quebec is a different province. We have a particular problem in our province - a problem of survival as an ethnic group and we think this is a matter of very great importance. Maybe it is not the same problem with many other provinces but I think family planning must be a part of a policy. World policy now is to diminish the birth rate but in a small minority, like we are, if we want to continue as a small minority in 40 years, many things must be started now. That is why we are working at the government levels and will take the measures that are necessary.

Chairman (Dr. Lennox) -

You are not saying that you have to have a population policy before you can articulate a family planning program?

Dr. Mongeau -

No. This is part of our work now. We did family planning without any population policy up to now but we feel that the moment has come for the government to have a population policy.

Speaker -

Can I know what kind of people took the training sessions -

what group of society did they come from?

Dr. Mongeau -

Yes, more than 2,000 people followed these lectures. They were given on week-ends, one or two week-ends depending on whether the sessions were of fifteen or twenty hours. Candidates were recruited from among the multipliers I named, the priests, and nuns, because they still have an influence on the moral aspects of family planning. Not many doctors attended because they always have the impression they know everything. Social workers were very important and most of the time they organized the sessions. Nurses also attended, as well as representatives from the family groups and teachers. Teachers were especially interested since there are so many problems at the school level with the sexual aspects of family planning. This has resulted in many lectures now being given in many schools, secondary schools or colleges for teen-agers.

Chairman (Dr. Lennox) -

Very good, are there any other questions?

Speaker -

Est-ce que vous pourriez dire si vous utilisez ou, si vous envisagez d'utiliser des méthodes audio-visuelles?

Dr. Mongeau -

We are not using many audio-visual aids. We developed a set of slides from other films that were produced in the U.S.A. but they are very bad. We started with these because we did not have anything else and we did not have the money to produce them. We wish to be able to develop a good set of slides soon and would like to use all kinds of audio-visual aids since information is a big part of family planning. People are not yet ready to use things without questions - they want to know why they use this, and how it works. Audio-visual aids help to answer these questions. We feel that audio-visual aids would be very useful for motivational purposes on the under-developed area of our province. However we begin, we want to be sure of what kind of audio-visual aids are needed because one of our fears is that such projects designed for under-developed areas will reach middle-class people only. Many things of this kind have already been done and the people who get the information are not those who need to be motivated. We feel that to go to the poor sections of the cities or the country we must develop special techniques, special approaches - perhaps with audio-visual. We don't know yet.

Mr. Archibald -

Although you are not involved in active service delivery,

do you have any opinions as to how a family planning clinic, for example, should operate using the other professional people that you were talking about? If you do, I would like to know what your opinions would be, as how you would work with a single girl coming into the clinic and what sort of things she would be exposed to.

Dr. Mongeau -

I said that we are not oriented to direct services but we do operate a clinic that is open two days a week. Here we are working on clarifying the role the various professionals could work in a clinic exploring the different aspects that must be taken into consideration during consultation with teen-agers or with any other kinds of problems such as mental deficiencies, alcoholism and such problems. I think the biggest problem for the teen-agers is the access to the services because, in many instances, services are refused to them or they think the services will be refused to them. There are no special problems unless choosing techniques that will not be dangerous to their health or techniques not requiring much planning. We are using the doctor in our clinic as a technician with perhaps the least important function. The doctor can see many patients in an hour if he just has to make an examination and give people the technique they have previously chosen.

We are using the social worker for the special problems. If you have someone who has changed techniques five times in the last three months you have a problem. Or, if you have an alcoholic who chooses, for instance, the rhythmic technique, it won't work, also for the sterilization technique because we know the effects of sterilization are not physical but psychological. Therefore we must assist people in making the right choice.

We use social assistants in perhaps the main function. They provide continuity to the clinic. Each time people come to the clinic, they see the same person, somebody in whom they have confidence. This is very important. These persons handle all telephone calls, and provide the personal relations that are necessary in this kind of consultation.

Finally, the nurse's main function is to help the doctor. This, basically, is what we are doing. I think we are working more to a definition of functions to be filled than to definitive roles to be taken by different professions. The important point is to have the function. Perhaps, in a few places, the doctor may do more, in other places, he may do less, the nurse may do more. What is important is that all needs are met.

Chairman (Dr. Lennox) -

Within the research component of your program, what types of research are you presently engaged in? What areas of research? At the conclusion of these studies, do you propose to publish the results of your explorations and enquiries?

Dr. Mongeau -

Yes, one is under the poor sections of the rural centres of the province of Quebec which will help us to know what kind of services are necessary for them - what values they give to the child, what kind of motivation can be used and finally what kind of policy the government should have with regard to these poor people. If they think the child is important, perhaps government policy should be not to cut the children and perhaps give more allowances since in our province we want more children. Regarding abortion, I think that it will be easily shown that even an illegal abortion does not have such bad psychological consequences as was feared in many instances. We are working to establish the kind of psychological support she needs. At the clinic, we are working to clarify the role of the social assistant, the central person who has contact with the people. We want to have, in our clinic scheme, one person who will provide the continuity as well as other professionals who can be switched around anytime. It would therefore be possible to use different doctors, and not effect the personal relation since there is one central figure. This year we want to begin research on sterilization - what are the effects of voluntary sterilization? How is it accepted? What kind of support must be given to the people so that it can be performed without ill effects.

Chairman (Dr. Lennox) -

Did I hear you answer about whether you are going to publish?

Dr. Mongeau -

It will be published with the help of the Federal Government since it was part of the grant we asked. Part of the grant will be used for the publication.

Chairman (Dr. Lennox) -

Are there other questions?

Speaker -

May I ask Serge if those social workers training reports are going to be published?

Dr. Mongeau -

We have already asked the Federal governemnt for money to translate these lectures. They are not perfect but since Canada now wants to do something in family planning and we have no specific instruments for the training of our people in family planning, we think such lectures could be of some help, at least

while waiting for more definitive material such as textbooks for social workers, nurses etc. I think we are a little bit lazy in many cases. We say, "Well the U.S. is just like Canada" and we go there and take what they have. But the U.S. definitively has a different policy than us. They do not give the psychological aspects of family planning enough emphasis. Many Americans still think that the problem of family planning is a problem of technique - if you find a good technique you will have the solution to all problems. This is not true at all, even with the good techniques we now have, even they are not perfect. People do not have as many children as before but we still have many problems. In the province of Quebec, we estimate there are between 10,000 and 25,000 abortions a year and if you look at the official statistics you will find that only about 1,000 abortions and it is because we have problems with our techniques even though the pill and the I.U.D. are quite easy to obtain.

Speaker -

I just wonder Mr. Chairman. Dr. Mongeau's figures on abortion - where would he get those figures. Are those figures from people that have come to your clinic?

Dr. Mongeau -

These are indirect figures obtained by the department of Demography at the University of Montreal. They took, I think, ten different ways to calculate them but they did not go to the population. That would have been too costly. After many calculations they informed us that it was impossible to have less than 10,000. That is why 10,000 to 25,000 is quite wide as an estimate but it was impossible to have less than 10,000 abortions. I think such a statement, since all the Quebec women who answered this questionnaire, (last month I think it was published) 37% had already had an abortion. We know that abortion is very frequent and I do not think it is just in the province of Quebec.

Chairman (Dr. Lennox) -

Thank you. Does anyone know the exact date of that particular issue of Chatelaine magazine? I have a copy but I have forgotten what the date is. Is it March 1971?

Are there other questions? If not, I would like to thank Dr. Mongeau most sincerely for a fine presentation. You can understand why we are always happy when Serge comes to address the group on family planning since he has a great deal of in-depth experience. I would like to thank him for straightening me away; I thought there was a service component and I learned differently. We are very grateful for your presentation. Thank you, Serge.

Dr. Watkinson - (Chairman)

Let us now examine the federal program resources - starting with the Hospital and Medical Care Insurance Programs. Dr. R. A. Armstrong of the Department who is Director of the Medical Care Program of the health side has kindly consented to speak to this item.

Dr. Armstrong -

I think it is probably a fair assumption that all of you, or most of you, have heard about Medicare so I do not need to say too much about what it is. But Medicare differs from previous insuring mechanisms for professional services in Canada, primarily in two ways. In the first place, there is no geographical limitation on where the services are rendered, in the patient's home, the doctor's office, the hospital, in the middle of a field or where have you. Secondly, there is no fine print in the coverage. There are no arbitrary limitations on the number of visits or the number of dollars of benefits which can be provided, except in the sense that the patient really must require the services.

All of the provincial medical care plans cover physicians services that are traditionally and obviously accepted as being required. A patient with pneumonia, or a person with appendicitis, a pregnant woman, all of these quite clearly require a professional service and that is automatically covered. There are some categories of border-line services where there is no universal agreement as to the desirability or the necessity and, in these areas, there is some variation among the plans. For example, the frequency with which routine check-ups are covered, the extent to which purely cosmetic procedures will be covered as opposed to those which are necessary because of some defect in function or structure of the patient. Birth control falls into this category as well, because there are people who do not believe in it, although I think they are now in the minority. It is in this category that the Federal Act has not laid down obligatory category or obligatory floors but the Federal Government leaves it up to each province to determine how far it wishes to go in this field. When the medical care program first began and as individual provinces first began to come in, they tended to be a bit cautious about providing coverage in areas which were border-line of which this is one.

The first six months of a year of a new medical plan is just hectic. They just try to keep the paper moving. After that, they begin to take time to look at what they're paying for. They begin to make plans for making changes in the administrative arrangements or in the benefit coverage to deal with given situations. We have had a chance to reflect on their policy in this field and

others are beginning to consider making changes. The majority have already made changes in their policy regarding family planning, birth control and sterilization.

At the present time British Columbia, Alberta, Saskatchewan, Manitoba, Ontario and New Brunswick cover vasectomy, the insertion of I.U.D., fitting of diaphragms, and birth control information without any qualifications to speak of. The Northwest Territories, which starts Medicare a week next Wednesday, intends to cover these procedures. The Yukon, which has not yet set a date and is the only one out at the moment, intends to cover them but has not yet set the date for starting. It will be sometime in the months to come. In the case of Nova Scotia, Prince Edward Island and Newfoundland, these procedures are all covered but the plan looks for some indication of medical necessity. Of these, Nova Scotia is re-examining its policy and may change to conform with the majority of provinces which no longer look for medical necessity but are prepared to extend family planning as justification in itself. Quebec is a little bit obscure because it depends upon whom you ask. The Department of Health has come out quite clearly saying these are covered. The plan has indicated they intend to look for some indication of medical necessity. There is a little bit of confusion there but it is a benefit, at least subject to some indication of medical requirement on the part of the couple. Probably, in practice, that will not be insisted on in too great detail, particularly in the early months when the plan will have considerable problems just keeping up with the flow of paper. I think, as a matter of practical policy, there will not be too much opportunity to spend too much time screening these. That is the present situation regarding the insured status of family planning and birth control services. As I mentioned, the government of Nova Scotia is taking another look at its original requirement of looking for medical necessity or some indication of it.

Now, there has been a recent development which I am sure will be interest to you. For many years, the Armed Forces refused to provide vasectomy to servicemen at public expense and this caused a problem for some of the service families. They have now reconsidered their policy and have ruled that it can be done and it can be done in the Armed Forces hospitals or DVA hospitals, subject to certain conditions to be met. Where these do not exist or where the DND surgeons are not willing to perform it, the serviceman can then be referred to a private surgeon and the cost will be paid by the department. This is just a recent development. I'm not sure it has been made public but it is official and presumably, within a few weeks, there will be some kind of notification going out. I would be pleased to attempt to answer any questions, if there are any on this matter.

Dr. Watkinson -

Thank you, Dr. Armstrong. This is an important resource available to all of us and this is a very good opportunity to

follow up this presentation with any questions. I'm sure this kind of information is of use to you not only in this program but, as well, in other programs.

Has any of you in the provinces had any difficulties in the use of the Hospital or Medical Care Insurance plans, any difficulties you're aware of?

Mr. Burns -

In Nova Scotia we have had those problems that Dr. Armstrong has pointed out but I was not aware that we are reaching a point where this will be resolved.

Dr. Armstrong -

At the February Ad Hoc meeting on Family Planning I said very much the same sort of thing I have said here. Some of the doctors present from Nova Scotia got up and spoke with some feeling as to what they consider to be bureaucratic intransigence which required doctors to be a little bit dishonest in the way they presented their claims. I think, as a matter of practicality, it is very easy for a doctor to submit a claim that would be accepted but perhaps they are more curious down there than they are in some other places. In any event, they spoke very strongly on this - that they should not have to play games in order to get these procedures covered for their patients. They were very interested to hear that we were quite prepared to recognize these costs for cost-sharing purposes. It was suggested that they go home and get the local people to re-examine their policy and, low and behold, about a week later I received a letter from the commission in Nova Scotia saying they were going to re-open the matter and take another look at it.

It is, after all, not an economical matter. These days, health costs are a very topical subject. It does not save money to pay for the confinement of a woman in hospital, to pay the hospitalization of a new-born for whatever period it requires, to pay the obstetrician to provide the pre-natal care and the delivery and then pick up welfare costs additional to that family's extra mouth, which is often the case, and pay extra family allowances to that family. That is not cheaper than paying a few dollars for birth control advice and services. I think it is inevitable that all provincial plans will provide such services much on a basis.

Speaker -

Mr. Chairman, in case anybody thinks that this would be the solution to the problem I would like to say that we have many reports from our Public Health nurses where they send the women whom they counsel to their doctors, the next time they see them they're pregnant. We have so many doctors yet who do not do anything about this. They tell these women they're perfectly healthy to go home and have babies.

Dr. Armstrong -

I think this is undoubtedly true. Certain doctors won't believe in birth control any more than certain patients will, but this is gradually changing. It does not do anything to improve the situation if the doctor knows that such services as he does provide are not going to be covered whereas if he sends the patient home and she comes back pregnant, his services are covered.

Dr. Watkinson -

Thank you Dr. Armstrong.

Mlle Dutil -

Permettez-moi de souligner qu'au Québec la situation s'est clarifiée. Depuis un mois et demi, les hôpitaux ont reçu une directive permettant la vasectomie et la ligature de trompes sous la seule condition de résidence au Québec depuis trois mois. C'est assez clair.

Dr. Armstrong -

Yes, I know the Department of Health has come out and said that this is quite in order but the Medical Care Plan which pays the doctor's accounts, the hospital accounts, are paid by different agencies and the Medical Care Plan people were not quite so prepared to agree unequivocably without any condition. I think in practice this is what will happen but, so far as the hospital is concerned, if he operates in hospital I'm quite sure it is covered - it's what goes on in his office.

Mlle Dutil -

Pourriez-vous maintenant m'informer de ce qui se passe dans les autres provinces? La ligature de trompes est-elle acceptée au même titre que la vasectomie?

Dr. Armstrong -

Yes, vasectomy is covered in all provinces, except Nova Scotia, Prince Edward Island and Newfoundland look for an indication of medical necessity. The other provinces accept it as such.

Mr. Archibald -

Yes doctor, could you tell me if there is any way whereby the fees of doctors who are utilized in family planning clinics could be recaptured through the medical care plan?

Dr. Armstrong -

As a matter of fact, the federal government recognizes, for cost-sharing purposes, the cost of providing insured services through provincial and municipal physicians. We also recognize a certain proportion of the salaries of the Department of Health of Alberta and of the municipal officers of health in proportion to what they spend in insured services. Some of them spend a very high percentage of their time, some very little, but this is sorted out. Where you have medical officers of health providing organized clinics for Child Health or for Maternal Health or providing birth control advice, let us say to the public, this could be claimed from the medical care commission in accordance with the rules we have drawn up to govern this type of operation and it would be recognized by the federal government for sharing purposes.

Dr. Khazen -

In Ontario, OHSIP was not covering family planning clinics. This means that the clinic itself had to find the money to pay for the doctor, either on fee-for-service basis or per session. There was one clinic that bypassed this difficulty - the five obstetricians involved in the clinic formed themselves as a group with a health unit and they were collecting from OHSIP through this arrangement, but this was not accepted for every health unit. Before coming here, Research and Planning showed me a memorandum to the effect that this is going to go into effect, I believe, perhaps this week. OHSIP will then pay for the patient going through public health clinics for family planning.

Dr. Armstrong -

I think you brought in a side issue here. The federal government looks to provincial costs and not necessarily costs only linked with the medical care plan. If the provincial department of health is spending the money on it even if it is not going through OHSIP's books, it is potentially shareable. As a matter of fact, I went through a book that thick of expenses by the Ontario Department of Health most of which did not go through OHSIP at all. I rather suspect that there is money going to the Ontario Government in respect to a lot of these services whether or not they deal with OHSIP.

I have been asked on other occasions what the status of abortion is in relation to medicare. The answer is quite simply that if the abortion is legal in Canada, that is to say it is done for medical reasons, then it is covered. However, an abortion which would not meet the requirements of the Criminal Code of Canada obviously is not a benefit because it is not medically required and I don't think we can share the cost of something that is a violation of the Criminal Code.

Dr. Mongeau -

What about an abortion in the state of New York?

Dr. Armstrong -

Well, I think exactly the same rule applies. I do happen to know that in the case of some Ontario residents who went down to New York state and submitted their claims to OHSIP, the plan asked to have evidence that the abortion was performed on medical grounds. If they could produce evidence that there was medical consultations at the hospital and that it was felt to be medically required, then OHSIP would pay the account. But, in most of these cases, the reason they went to the States is because they wanted an abortion with no questions asked and obviously, in those cases, they cannot produce the medical consultation reports indicating an abortion was required. I believe that all the provincial plans would follow that same practice.

Dr. Watkinson -

Anything more? Thank you very much Dr. Armstrong.

Can we move now to consideration of the Canada Assistance Plan and I would like to turn this part over to Mr. Norman Knight.

Mr. Knight -

The Canada Assistance Plan is a federal statute which authorizes the government of Canada to enter into agreements with the provinces to share the cost of provincial assistance and welfare service programs. It permits the federal government to reimburse the provinces 50% of specified expenditures by the provinces and by their municipalities on such programs. Under these arrangements, Canada can deal directly only with the provinces. The involvement of the municipalities in the payment of any or all of the other 50% is entirely within the authority of the provinces. We can also share provincial and municipal expenditures for specified purposes which are made through non-governmental agencies approved by the province, but there is no provision for the sharing expenditures of private agency contribution.

These aspects of the Canada Assistance Plan which are most relevant to the provision of family planning services are contained in two of its major innovations. The Plan authorized federal contributions to health care and to administrative and welfare service costs of provincial welfare programs. Health care services, the cost of which may be shared when supplied to persons in need, are broadly defined to mean medical, surgical, obstetrical, optical, dental and nursing services and include drugs, dressings, prosthetic appliances and any other item commonly associated with

such services. Under this provision, the Federal government is prepared to reimburse the provinces 50% of the cost of contraceptive medication and devices prescribed for persons who have met a test of need. The cost of services of physicians and related medical personnel involved in the provision of family planning services, as part of a health care program for needy people, is shared on the same basis provided, of course, that these are not already being shared through other federal-provincial programs such as hospital insurance and medicare. We know that all provinces are using the health care provisions of the Canada Assistance Plan. It is mandatory for the provinces to supply certain kinds of assistance to needy people such as food, clothing and shelter. However, since the provision of health care is optional, the extent to which this is supplied varies from province to province. All provinces are, to some extent, supplying contraceptive pills and I.U.Ds. to persons who have met a test of need, usually recipients of other kinds of welfare. In some provinces people are eligible for health care services only if they are also eligible for material assistance but this is not a federal requirement.

Welfare services are broadly defined under the Canada Assistance Plan as those services having as their object the lessening, removal or prevention of the causes and effects of poverty, child neglect, or dependence on public assistance. Examples of such services, specified in the federal statute, which may be particularly relevant to family planning activities are case work, counselling, assessment and referral services, consulting, research and evaluation services and administrative services, including staff training, related to the provision of welfare services or assistance. Shareable welfare services are not limited to persons who have met a test of need but may also be provided to persons who are likely to become needy unless provided with such services. We have deliberately left "a person likely to become a person in need" undefined but it is intended to refer to the lower income segment of the population. For example, if you have a public housing or slum clearance area where the income of the average resident falls in the lowest third of the income of the general community, we're prepared to accept the total population of that area as persons likely to become persons in need unless provided with services. We have shared the cost of community development workers operating in such an area. Federal-provincial agreements under the Canada Assistance Plan commit the provinces to the continued development and expansion of their welfare services. However, the speed and direction of such development is determined entirely by the provinces.

Provincial welfare departments have been informed that all reference to dissemination of information about contraception has been deleted from the Criminal Code and that authority in this matter is vested in the Minister of National Health and Welfare under the Food and Drug Act and Regulations. These now specifically authorize the dissemination of information about contraception by all levels of government and by non-profit organizations.

I mention this because the misunderstanding seems to crop up every so often that there is still some sort of restriction in the Criminal Code about the dissemination of information by governments or non-profit agencies. The only restrictions which are now in the Food and Drug regulations relate to advertising of contraceptive methods which require a prescription. There is also a prohibition against advertising contraceptives to the general public by the distribution of samples door to door or through the mail.

I would like to mention a couple of specific areas in which we can help the provinces under the welfare service provisions of the Canada Assistance Plan. We can share fees to professional consultants advising welfare field staff about family planning information to be conveyed to clients of the agency. If a provincial or municipal welfare department wanted to commission a university, a social planning council, or a family planning agency to undertake an attitudinal survey of welfare recipients, this would be a shareable cost under the Canada Assistance Plan. Shareable costs include travelling and living expenses related to conferences, seminars, and other training opportunities designed to equip staff to implement family planning aspects of welfare agency programs.

I should also make reference to a specific provision of the Canada Assistance Plan relating to child welfare. Part of the definition of a person in need in the Canada Assistance Plan is a person under the age of 21 who is in the care or custody or under the control or supervision of a child welfare authority or a person who is a foster child. Under the Canada Assistance Plan we're prepared to share the full range of assistance, health care and welfare services that the province decides to make available to persons who meet that description. I should add, that as far as the federal statute is concerned, marital status is irrelevant to the provision of welfare assistance and services. Finally, I would like to mention that, as indicated in the recently published White Paper on Income Security, the Canada Assistance Plan is now under intensive review. I can assure you that any possible way of improving the potential of this statute for the support of family planning programs will be given the most careful consideration.

Dr. Watkinson -

Thank you very much, Mr. Knight. This is very good indeed. It sounds like a lot of assistance at least for certain segments of the population.

Mr. [illegible] -

Just one question to clarify the point Mr. Knight made. There is no restriction in the Canada Assistance Plan for children who are wards, regardless of what income their parents may have.

Now, when you moved on to provisions for family planning there are no restrictions as to marital status. Does it mean the same thing in terms of age? You did not state that explicitly.

Mr. Knight -

As far as the Canada Assistance Plan is concerned, there is no restriction in relation to age except that the definition of a person in need applied to a child in care is limited to a person under the age of 21.

Mr. Burns -

Could it also be interpreted that the government is in favour of supplying family planning, counselling, information services, etc. where required for children under 16?

Mr. Knight -

I would say this is a logical inference.

Mr. Bethune -

Mr. Knight, is CAP prepared to give any special emphasis to family planning programs? Does the same type of agreement apply to all welfare services?

Mr. Knight -

This is the situation at the present time. As you know, suggestions have been put forward that a differential sharing formula be considered for the Canada Assistance Plan. This, of course, is a major matter of policy which is under consideration.

Mr. Bethune -

But this is no change in policy. This would always have been considered a welfare service, would it not?

Mr. Knight -

Nothing I have said to-day constitutes a change in welfare policy. What I am doing is identifying the areas of the Canada Assistance Plan which offer a facility to the provinces for the development of family planning programs.

Mr. Bethune -

What I have been getting at is this. At this point we have heard no word as to any new money becoming available to the provinces and it does not sound as if there will be more money made available to the provinces under the CAP.

Mr. Knight -

I can't predict the future, Mr. Bethune, but at this point in time, the answer is no.

Mr. Mongeau -

You said that the Canada Assistance Plan would be ready to share the cost of services given to the needy. Would it pay for all the personnel involved if the service required doctors, social workers and others? Would it be for all these or just for the doctor?

Mr. Knight -

Briefly, there would be two qualifications attached to the sharing of costs in this instance. First of all, the person must be determined to be a person in need under provincial law. Secondly, the sharing of the costs of all personnel in the provision of the service would be shareable to the extent that they are not already being shared under another federal-provincial agreement.

Mr. Cornish -

Would that apply then to a private group of - let's say a neighborhood community centre deciding to institute a family planning clinic and setting up the whole structure that Dr. Mongeau suggests?

Mr. Knight -

Yes, provided the persons who are being referred to that service by the province or the municipality had met a test of need prescribed by provincial law.

Mr. Cornish -

You mentioned the other aspect - the geographic area which that community centre was serving, I think you said within the lowest third of the income range. Would this apply to that group?

Mr. Knight -

This gets us into some really deep water, Mr. Cornish, because it involves the difference between a health service and a welfare service. A health service is shareable only as an item of assistance provided to persons in need while a welfare service is shareable on a different basis and is available to persons who are likely to become "persons in need" as well as to persons in need. A welfare service is defined by the Canada Assistance Plan so as to exclude any service which is wholly or mainly a health

service. The type of service you describe, to be available to persons who are likely to become "persons in need", would have to be so structured that it was not essentially a health service. I'm sorry that sounds complicated but it is the situation. I would be glad to discuss it with you later in further detail in relation to a specific situation, if you wish.

Dr. Severs -

I would just like to have some clarification on the reference which was made to the advertisement of non-prescription birth control items and perhaps some explanation as to why the regulations are as I think they were described.

Dr. Campbell -

There are, I think, at the moment, no regulations governing this. There are new regulations in the process of evolution. Until the changes in the Criminal Code, of course, the question just did not arise so that the Food and Drug Regulations did not cover this point at all. There is a revision of the regulations going on at the moment which may or may not contain regulations on the direct advertising of contraceptives to the public. We already monitor advertising of contraceptives to the professions.

Dr. Watkinson -

Does this answer the question?

Dr. Severs -

This is probably not quite to the point but, on the one hand, we're talking about an education program for the general public. On the other, as I understand it, a druggist, for example, or some mail order house, cannot advertise non-prescription items. Is this right? Canada Druggist for example advertise condoms and say they're good for birth control or for family planning?

Dr. Campbell -

I believe that there are two amendments made to the advertisement of products. One was the restriction of advertisements for contraceptive pills which had to be prescribed by a physician. There was also a restriction in the advertisement of intra-uterine contraceptive devices which were to be utilized by physicians and inserted by the medical profession. These were excluded from the advertising realm. All other items such as foams, jellies, condoms, diaphragms, you could sky write or do any kind of advertising that was within good taste.

Dr. Khazen -

It has been advertised in the newspapers and in magazines

specially for the male product. I would like to ask a question. Is there any law concerning vending machines for condoms placed in public places?

Dr. Watkinson -

Does anyone know about this?

Speaker -

I understand, although I have not seen them myself, there are vending machines for condoms in some universities. I would assume from that there is no law against their use.

Dr. Grocott -

At the University of Saskatchewan they certainly have such machines in the students' union building.

Speaker -

And in Alberta, in Edmonton.

Dr. Khazen -

I know provincially they don't have any of those.

Speaker -

They do in Nova Scotia too, Mr. Chairman. Also, they advertise condoms in the newspaper.

Speaker -

And British Columbia, in the universities.

Dr. Watkinson -

Well, can we get back to the Canada Assistance Plan?

Mr. Huesing -

Mr. Chairman, this is a question for Mr. Knight. With regard to the matter which the gentleman in that corner brought up: where you have, say volunteer organizations in the community, in order for that organization to qualify for assistance under CAP, would it not have to be recognized as a service for that purpose by the province before it would be eligible for a 50% federal grant?

Mr. Knight -

It would have to be what we call a provincially-approved agency. The Canada Assistance Plan defines a provincially-approved

agency as one which has been approved by the province for the provision of assistance or welfare services and is listed in a schedule annexed to the provinces agreement with us under the Canada Assistance Plan.

Mr. Huesing -

Thank you.

Mr. Gaudet -

Are there not situations in which certain drug aid clinics have been approved under CAP for persons up to age 21 whereby these people would be deemed to be people in need and therefore could benefit from this program re drug education and treatment?

By inference, therefore could we not say that this is going into the area of family planning?

Mr. Knight -

I am not aware of the kind of service such as you describe as having been approved for sharing under the Canada Assistance Plan. I would be interested in any specific example you could give me.

Mr. Gaudet -

I believe that in Toronto there is a drug aid program. Perhaps it is under a demonstration project. I would not know, but I thought it was under CAP.

Mr. Knight -

I would be inclined to think it's a Welfare Grants project, but we could check that out.

Dr. Watkinson -

If that is all that needs to be said at the moment on the Canada Assistance Plan, can we now turn to National Welfare Grants. Would Mr. Papove and Dr. Kelly please come forward.

Mr. Papove -

Thank you, Mr. Chairman. I propose to skim over briefly the background to the National Welfare Grants Program, identify its general purpose, its essential components and the kinds of things that might be possible for us to entertain under the Welfare Grants Program. My colleague Dr. Kelly will speak on the research aspects of the program.

The National Welfare Grants Program was established in the autumn of 1962, primarily to serve as a financial and technical resource to the welfare field in Canada for the purpose of developing and improving welfare services. The cost sharing is a residual sort of capacity which we retain in the National Welfare Grants Program largely because our big brother, the Canada Assistance Plan, has become established and has been funding staff development activities for which purpose that sharing aspect was originally established in the Welfare Grants Program. That is, the residual capacity which we maintain is essentially to assist the provincial departments with the awarding of bursaries for social work education and this has particularly been used by most provinces. There is a capacity for us to cost-share in the training activities which involve staff of those voluntary agencies that are not acceptable for sharing under the Canada Assistance Plan. We are also able to accept staff development, institutes, seminars and the like, which involve staff of agencies which are not acceptable for sharing under the Canada Assistance Plan.

Those other components of our program which involve complete funding from the welfare grants sources include welfare demonstration projects. These are grants which are available to provincial and municipal organizations, voluntary welfare agencies, and other organizations which are designated as welfare agencies under the National Welfare Grants Programs.Grants are available, basically, for three purposes. The first is to encourage existing service assistance to experiment with new and innovative ways of providing services. The second major aspect of the welfare demonstration projects is to encourage the undertaking of experimental activities in response to social problems - for example, alienation as well as emerging social needs into disparities and services arising out of a variety of difference either regional, cultural, ethnic or whatever. Finally, the third important feature of grants for welfare demonstration projects is to assist local groups, for example, local community people, to come together to identify what their problems might be in the welfare sense and collectively, seek to identify ways and means to resolve them. So grants have been available for this aspect, if you like, of social development as against grants for demonstration of new methodology of service delivery and that sort of thing.

Under this particular component of the Welfare Grants Program, we have received within the last week a request from an agency in one Ontario city for consideration of a demonstration project designed to train so-called indigenous workers to provide family planning information to groups which have not up to now sought this service. The idea is that the so-called indigenous workers are going to be mothers who are currently in receipt of "Mothers Allowance". The idea is to train them to deal with this facet of family planning and to work in the community to which they are indigenous.

Another component of welfare grants is the provision of grants to national voluntary worker agencies for such undertakings as studies, surveys, seminars, institutes, consultations, on a national basis on topics of national significance. For example the Study into Transient Youth which the Canadian Council for Social Development undertook about a year and a half ago was funded through this component of our program. Other reasons for grants to national welfare voluntary agencies are to identify and predict social trends and associated problems and to assist agencies, for example, to look into their administration with a view to developing better coordination of services.

A final component of the program, at the moment,deals with training and falls under the heading of welfare Manpower Development and Utilization. Initially, grants under this particular component were designed to increase the capability of schools of social work to expand, to accommodate anticipated increases in the enrolment of social workers and to provide grants for the purpose of organizing and planning of new programs. Most of you are undoubtedly familiar with the development of the baccalaureate program in social work education. In effect, the baccalaureate degree in social work has become, or is becoming, the first accepted degree. Hitherto the Master's degree was the accepted operating level. In addition, grants were provided to individuals interested in pursuing an education and career in social work. These were, as I mentioned earlier, not only bursaries, which are shareable with the provinces, but also welfare scholarships. This component of our program is now suspended largely because there is a feeling that a sufficient number of people are emerging into the field from university level programs as well as graduates of CEGEP community colleges and technological institutions across the country.

The National Welfare Program has accounted for an increased demand for funds to undertake various kinds of projects in the various components I have identified. The point now is how to maintain a fine balance between the capacity to respond to sound undertakings in these areas on one hand and to reconcile the existence of essential static resources on the other. Insofar as projects are concerned exclusive of those which may be funded in the family planning area, clearly money ought to be available now to make a substantial impact but insofar as our program is concerned at this point, Mr. Watkinson alluded to the fact that, owing to budgeting patterns, a good deal of planning has identified various objectives reaching into future years - two or three years in advance. In a similar vein the kinds of projects we have funded under the welfare grants program have a life of one, two or three years - in essence, these projects are terminal and ordinarily do not exceed the three-year duration. At least, they have not in the past, so the various areas we have funded up to this point, under welfare demonstration projects, have committed our money to succeeding years so that there is a little amount of money essentially available to devote to sound undertakings which emerge such as family planning. This is not intended to discredit but is simply an indication of the reality under which all of us operate.

Now, I turn to the capacity we may have under the Grants Program to act as resources in the family planning field. I think before getting into that, I should indicate that we recognize, essentially, two dimensions to the issue of family planning. One is physiological, the other social-psychological. It is with the latter that we are particularly concerned on the welfare side of the department. It is, by its very nature, one that involves the consideration of the implications of psychological health and social stability of the fundamental social unit - the family - and the individuals within it. It seems to me that we have stressed essentially the preventative aspects - control of conception and fertility for example. There is another dimension, and perhaps I have missed it in the course of our discussions, and this is to assist couples who wish to have children and who may ordinarily have problems in this area. This is recognized as a highly personal and a value-laden issue and when you consider the training of people to work in this area you have to recognize that they must be confident, knowledgeable and skilled to work well. You will recognize at this point that the grants to provinces on a shareable basis can be used as a resource for the training of personnel to work in the family planning area. Similarly, bursaries which are also shared with the provinces by the federal government on a 50-50 basis can also be used to acquire knowledge and skill in this area. There is another aspect of our program - welfare fellowships for which grants are made to individuals interested in pursuing studies at the doctorate level.

I particularly subscribe to the kinds of things that Dr. Mongeau has identified. I think we ought to concentrate, in the short run, on what might be called training of trainers with the multiplier effect emerging out of that. Resources for long-run purposes exist as I have mentioned. In the long run, there would have to be additional undertakings to permit schools of social work to respond, to accommodate in the curriculum the content aspects which have to do with family planning. That, ordinarily, should not be a difficult problem because human behaviour and social development are essentially the nuts and bolts of social education. It is a matter of introducing family planning as an additional dimension into it.

Dr. Watkinson -

Thank you very much, Mr. Papove, for a most complete and useful presentation. I think that in the interest of time you might hold your questions until we've covered Dr. Kelly's portion too. Would you now speak, Dr. Kelly, with respect to the research aspects?

Dr. Kelly -

To continue from where my colleague left off, let me highlight first of all that welfare grants are available not only to provincial departments but also to a range of other organizations broadly defined under the rubric "welfare agencies". Moreover, the funding is 100% federal. I thought that in this part I would speak to you not only about the research component of welfare grants but talk a little bit about research needs in family planning from a social welfare perspective. This will pull together some of the ideas that have been expressed by various persons here through the day. The aim is to attempt to provide suggestions.

We should say, of course, that heretofore the welfare grants programs, as far as research is concerned, has been purely a response program. That is to say, we operate by awarding grants on the basis of competitive applications. However, from the thoughts and discussions you have come forth with to-day, it would appear that people have been thinking in terms of directed research to a greater or lesser extent. This would imply, of course, the selection of priorities and possibly even moving in the direction of contracted research. We are not at that point yet, but we can offer you some ideas of the sorts of research on the welfare side which would probably receive favorable consideration.

Certainly we would first of all need to consider that, if you think of developing a research component to a family planning policy, an important part would be achieving some kind of on-going evaluation of the other parts of the whole program - in this case, the impact of the information activities and of the various training aspects.

Theoretically, of course, research precedes the development of other parts of the program. One could think, for example, research identifying obstacles to the effective use of existing family planning services or in specifying new types of services required or in pin-pointing the distribution among the population of values and attitudes contrary to the practice of birth control or family planning. Such information would clearly have some direct relevance to the planning and focussing of public information and in the training of personnel for the field. Of course, realistically, we recognize that to precede training and public information by research may not always be feasible. Therefore, we must expect that the research component of family planning programs would accompany the evolution of the other parts of the whole program. It would be necessary to press ahead with information and training on the basis of existing knowledge and informed opinion, such as the ideas you have presented here to-day. Nevertheless, we would hope that there would be progressive modification of information and training in the light of the sub-sequent, relevant research findings. We might, therefore, think the ideal terms of an overall research model or design would show the essential components of this family planning process running

all the way, for example, from the point of initial exposure to the idea right through to success in family planning. The idea would be to identify the points where research ..... is required to eliminate the nature of barriers to success.

When we come down to specifics, I think that we can say that welfare-oriented research in this field appears to fall into two main classes. We can think of demographic studies or surveys of whole populations as to attitudes, knowledge, etc. or we can take action-research such as an experiment designed for a smaller group of people in which we might try out certain techniques, let's say an informational technique. Now, being even more specific, it has been said here today that merely providing information about family planning techniques is an inadequate approach especially in the case of families who are handicapped by social, cultural or psychological barriers to making use of information and available services.

Therefore, it would appear that action-research projects are needed to stimulate potential recipients of service and to support their attendance at family planning clinics and subsequently to evaluate the outcome. Another area for study could be the benefits in terms of favorable outcome of supported counselling service as an integral part of any family planning or birth control methods, and the factors associated, let's say with failure to persist or failure to return to the clinics. Another project could be an evaluation of the effect of the informational media in family planning for different groups and different social economic strata. We might probe the most effective methods of establishing family planning services including such factors as the patterns of financing, methods of obtaining public support, and methods of attracting clients. Included in this is the whole factor of the feasibility of involving part of the public, the potential recipient, in the design of the service and possibly even in operating the service. There should be, perhaps, active research on some methods of involving low-income families in the design and establishment of a neighbourhood base for services.

Mr. Papove, my colleague, has already referred to manpower training and I would like here to amplify with a few thoughts how manpower relates to research in the field of the welfare aspect of the family planning. There is a need to look at the role of counsellors, social workers and others in family planning service delivery. We might think of ways in which the counsellor's training should fit him or her to stimulate and support the practice of birth control. The counsellor should be equipped to provide family planning counselling in the clinic itself. The in-counselling should include factors such as communication between the marriage partners and, incidentally, between parents and adolescent children, and toward acceptance of the basic concepts of planning itself. There is, finally, a need for on-going and forward counselling in the continous use of

family planning techniques.

Now, in this, research assets are implicit, in terms of evaluating the effect of most of these techniques. Under the research component of the National Welfare Grants program, we have, currently, four grants for projects funded by us, all of them in Quebec as it happens, and all of them related to motivational and related factors. We would be interested in receiving further applications whether it be from provincial departments or from other agencies across the country. We note that educational and health research is not eligible under this program. This program is for research on what is called "welfare" under the broad meaning of this term. Our interest is in research that is directly keyed to service programs. The potential for implementation into practice of research findings is an important criterion in assessing research projects applications. We certainly would be interested, as I say, to hear from you and to receive suggestions from you as to priorities which might need to be established. Thank you.

Dr. Watkinson -

Thank you, Dr. Kelly and Mr. Papove. We have had two excellent presentations on the National Welfare Grants. Are there any questions or comments?

Mr. Bethune -

I would like to ask the same question I asked Norm Knight. I take it there will be no change made to the basic rules of your programs to put emphasis on family planning.

Dr. Kelly -

At the present time, you're absolutely right.

Mr. Bethune -

So that, to this point we've heard nothing from the federal point of view that, at least in Saskatchewan, is going to help us accelerate development of family planning programs.

Dr. Watkinson -

That is right.

Dr. Kelly -

In fact, in so far as I might add, since you are competing with other kinds of applications, presumably the more activity, the more project applications you put in - whether they be demonstration, training, research or what have you-the better opportunity there will be for some funding to go in that direction.

Mr. Bethune -

Then, essentially, we've just been given a review of established federal programs.

Dr. Splane -

Mr. Bethune's comment, Dr. Watkinson, is a perfectly valid one. We would like to hear from him to-morrow under item 7, concerning any grounds which might indicate the adequacy or otherwise of the programs that have been described. We would be interested in hearing why the programs and resources would fail to do what he feels needs to be done in his province.

Dr. Watkinson -

We are not going to be too much longer to-day but I would like to take, at least, the Professional Training Grant. However, before we leave the National Welfare Grants would you like to direct any questions to either Mr. Papove or Dr. Kelly?

Mr. Archibald -

Just a short question. Do you issue a policy statement or a booklet for voluntary agencies to know exactly what they must do to apply for a specific grant?

Mr. Papove -

Yes, there is a manual, Mr. Archibald, which covers the grants for demonstration projects. There is a manual identifying the objectives and guidelines to the development of the project - what must be submitted for grants to voluntary welfare agencies. Dr. Kelly and I are in the process of making recommendations, in fact we have made recommendations, on policy changes in the areas of research and manpower so that there is no manual of that sort existing at the moment. Assuming acceptance of our recommendations by the Minister, we will prepare a manual which will be available for distribution but the other two exist already.

Mr. Van Der Veen -

This is to Mr. Papove, Mr. Chairman. I was involved with a request for a very substantial welfare grant while I was still with British Columbia and the organization was successful and received the grant but I would like to know if there is an on-going quality control, so to speak, during the three-year period this project is underway?

Mr. Papove -

The answer is "yes" and "no" for this reason. It depends on the time, Mr. Van Der Veen. In the initial period of the

development of the National Welfare Grants program we did not have the capacity for evaluation that we have now. From about 1962 to about 1964 or 1965, we did not have the technical ability to do as good a job as we might have monitoring the development of the project and evaluating its conclusion in these kinds of terms. Now we do have this capability so that the "yes" aspect is that we are aware that the monitoring has to go on to see whether, as the project rolls along, our original assumptions were accurate. We of the Welfare Grants Program generally get together to look at a project in order to determine whether its viable, whether it fits into the broad terms of reference of the demonstration project. There is also a requirement for record maintenance on the part of the recipient organization and the person who is involved goes out frequently to look into the project and to help. I am sure the same thing will occur in the research area.

Dr. Watkinson -

At this point I would like to call on Dr. Dupont, Director of the Health Grants Program, to tell us something about the professional training grants on the health side.

Dr. Dupont -

Mr. Chairman, because of the time, I'll try to be as brief as possible. The Health Grants were first introduced in 1948 and I'll try and provide a summary of where we are to-day.

First of all, may I say that of the two programs, or at least the two main programs under the Grants, one is directed through the provinces and the other which was introduced in 1969 provides for sums which can be distributed directly to agencies or governments. The general Health Grants to which I refer were introduced in 1948 and are administered in cooperation with the provinces and through the provinces. These can be divided into three main categories. There is a service component, a training component and a research component. The service grants which I will just enumerate and which are to be phased out at the end of next year are as follows: the General Public Health Grant, Mental Health Grant, Tuberculosis Control Grant, Child and Maternal Health Grant, Medical Rehabilitation and Crippled Children Grant. All of these can be provided at 100% within the allocations available, except certain aspects of Medical Rehab and Cancer Control Grant which draw a 50% basis. Some assistance has been, and is being provided, under the Child and Maternal Grant for educational efforts in the field of family planning including the provision of personal services. However, as I mentioned, these grants, except for the Public Health Research and the Professional Training, are to be phased out as of March 31st, 1972. Under the Professional Training Grant, assistance is made available to the provinces for the training of health and hospital personnel. There is an amount of approximately 2 million made available annually to the provinces for the training of hospital helpers according to

the priorities that they have set up to date. These bursaries are available for health training to undertake either the more formal academic programs or for short courses. In addition to a monthly living allowance, and this again is at the discretion of the province, we have certain guidelines which we make available to the province and they provide the bursaries in accordance with these guidelines. The trainee may also receive, in addition to his monthly allowance, travel expenses, tuition fees and an allowance for books and technical supplies. For short courses of less than 3 months, assistance may cover the actual living expenses in addition to travel, tuition and books as required, again within the allocation made available to the province. A trainee receiving training assistance is expected to provide a return service in the province to which the assistance was granted.

The Public Health Research Grant provides for support of studies in a number of public health aspects and in the prevention of disease, disability or death, epidemiological approaches, occupational health, mass screening programs with evaluation and so on. Research and studies on family planning as they relate to Public Health and the assessment of current health problems and their trends may well fall within the scope of this research grant.

As I mentioned earlier, there is a National Health Grant which was introduced in 1969. This new grant is in the amount of $2.1 million for the current year and is expected to have an amount of $3.2 in 71-72. It is designed to support studies, demonstrations, training projects and related activities aimed at improving our health care delivery system and which are considered of national interest. One factor here is that most of the health care delivery research that was supported previously under the Public Health Research Grant is gradually being transferred over to the National Health Grant.

It is conceivable than an innovative pilot project could fall within the framework of the National Health Grant Program. This could take the form of a new service with evaluation procedures of a conference or a seminar on research on family planning. I should add that in this respect, these matters should probably be considered as speculative since our review committee has not had to consider such a proposal to date.

If I had more time I could probably elaborate on the various sections or divisions under the National Health Grant, including demonstrations, new innovative approaches, educational or special training programs and so on. As a last comment, the research projects received under one grant program, if deemed more appropriate for consideration under another program may, after consultation, be transferred to the other program or programs. The applicant is so informed and advised to take whatever

action necessary. Again, Mr. Chairman, this has been brief. I'll be glad to answer any questions you might have.

Dr. Dupont -

These programs are not developed specifically for family planning. Under the professional training grant, there is an amount of over two million dollars made available to each province which is approximately 10 cents per capita. The province is asked to develop its own training needs and to submit projects within these priorities that they establish and within the allocation made available.

Dr. Watkinson -

In the few minutes that are left does anyone wish to direct any questions to Dr. Dupont?

Dr. Colford -

Does the training branch cover projects in family planning?

Dr. Dupont -

The training grant is for the training of individuals in the field of health. If the province feels that it wants to send someone to train in this particular aspect it is open to their decision and submission.

Dr. Mongeau -

Is it shared cost?

Dr. Dupont -

It is not shared cost within the allocation and the guidelines. The amount which would be made available is up to the province. Up to the present time we have offered a monthly allowance of $300 plus tuition plus travel and possibly $50.00 per year for books. The province can add more to that if they so wish.

Mr. Archibald -

Is it up to the province to decide what type of training could be supplied? Does it have to be a formal school of training, for example? Can it be seminars?

Dr. Dupont -

This would be covered under short courses and short courses involve seminars. We would not regard an annual conference as a training session but if it is a seminar specifically oriented towards family planning, this would well fall within the short course purposes.

Mr. Archibald -

What about training courses that are not traditionally called academic but constitute training through participating in the actual work, not a clinic.

Dr. Dupont -

If it is demonstrated that a person really is under training and is not merely there for service, this may well fall within this submission.

Dr. Watkinson -

Thank you very much Dr. Dupont. I believe that most of the provincial people on the health side are aware of the professional grant and its use. It has been in being for a good many years; however, if when you return, you have any doubts about the use of the professional training grant or the other grants in fact, I recommend that you write any of us for clarification. I suggest that if you feel you have a reasonable case and it falls within the application of any of these grants, that you do not hesitate to put forward a proposal to us in writing and we shall try to assist you in sorting it out. Before we end I want to thank everyone who has participated to-day, especially Dr. Mongeau who has come for this afternoon.

Tuesday, March 23

Mr. Strehler -

Ladies and Gentlemen. First of all, may I thank you very much for asking us to participate in this important conference.

The voluntary association is an integral part of any democratic society and enables people who are interested in the problem to unite their efforts for serious action. To do this, it works on three levels - informs and educates the public, brings pressure to bear on public authorities such as governments at federal, provincial and municipal levels and provides facilities if these are lacking if it has the personnel and financial means to do so. Translated into terms of family planning in Canada, the associations already in existence already have, with certain exceptions, concentrated on the first two levels.

The Federation is a Canadian member of the International Planned Parenthood Federation, the world's largest international agency concerned with family planning. The FPFC was started in 1963 when itwas known as the Canadian Federation for Population Planning which was changed in 1966 to our present name. The

Federation now has nineteen members which include Planned Parenthood Associations in Victoria, Vancouver, Calgary, Edmonton, Winnipeg, London, Hamilton, Toronto, Ottawa, Montreal, St. John, Fredericton, Halifax. Other members include the Anglican Church, Canadian Home Economics Association, Unitarian Council, Presbyterian Church, Salvation Army and the United Church.

All the planned parenthood groups are specifically concerned with information, education and services in the way of family planning. The other groups actively support the work of the Federation and utilize it as a source of information. All members receive up-to-date reports on world-wide family planning activities and have access to a growing library of audio-visual materials. The defined objectives of the Federation are to provide a national organization for societies and associations with similar objects and to represent such societies and associations for any national or international planned parenthood organization; to promote research and education on population problems both domestic and international; to inform the public on the problems arising from uncontrolled population growth, and to promote the understanding and adoption of family planning to encourage good citizenship through responsible family life.

On November 26, 1969, the Federation received a Charter under the Canada Corporation Acts and was granted charter status. Much of our effort up to August of 1969 was devoted to attempting to get changes in the Criminal Code mainly with respect to birth control information. This included efforts on behalf of some of our members to get arrested but not with much success. With that hurdle overcome, our role had changed significantly. We find ourselves in the middle of considerable interest in family planning on behalf of all levels of government on the one hand, and some rather frustrated citizens on the other hand who are dissatisfied that no family planning information or counselling is available in their area. We are presently working with concerned citizens in the following towns, all of them arranged to form some sort of group to fill a need in the area of family planning: Regina, Windsor, Thunder Bay, Sudbury, North Bay, Guelph, Waterloo, Kingston, Peterboro, Barrie, Sault-Ste. Marie, Sarnia, Welland, New Glasgow, Mountain, Timmins and even Yellowknife. Besides this community activity, we continue to have medical officers of health in various parts of Canada who are looking for sources of information, supply resource material to groups such as Anglican Church Women, Canadian Mental Health Association, Ontario Medical Association, Children's Aid Society, the United Church, educators, and members of provincial and federal parliaments who have prepared briefs or speeches.

Listening to work done yesterday by Serge Mongeau, which all of us admire a great deal, I still find it somewhat ironic that

I get letters while Serge is getting grants to train Francophone Africans. I get letters from doctors from rural Ontario saying, "Dear Brian, I was never trained about family planning. Could you tell me where I could get some training as I badly need it in my town". Even dentists, oral surgeons, have requested help on behalf of their patients. We have five letters a week at least, from teachers across the country, and last summer we had no fewer than 100 teachers in Toronto for one course or another who were determined to pick up resource material because of the demand upon many of their schools by the pupils for information concerning birth control. Many Canadian students at United States universities write to us about abortions and family planning because of papers they are writing. We seem to act as a clearing house for almost everything.

Another example is the city of Toronto. We talk about the ethnic mix in certain areas of Canada. The ethnic mix in downtown Toronto is as broad as anywhere in Canada, I suppose, and I'm glad that we are able to fill the need. None the less, this is an area where, if someone takes the trouble to call us or knows about us, we are often able to help. The members of our Board which is inter-disciplinary are constantly contributing articles, speaking to professional or lay groups or speaking on family planning on radio and television, all on a voluntary basis of course.

All planned parenthood associations have different priorities depending on official local involvement. Thus, while associations in British Columbia, Ottawa, St. John and Hamilton are actually involved in the running of clinics, others like Toronto, Halifax, Winnipeg or London are operating counselling and referral services. The Board's all-local associations reflect complete community involvement with the clergy, the medical profession, social workers, education, educators and concerned lay people usually being representated. I think it is very interesting that in one of our newest planned parenthood associations in London, Ontario, we have an Indian Chief from the reservation on the Board and the President also happens to be a professor of Astronomy at the University. I think this indicates the broad spectrum of people who are attracted to the voluntary association. Other activities of local associations will include public speaking, supplying literature, arranging seminars for volunteers or training courses for doctors, nurses and social workers and, of course, raising funds since all associations are pitifully poor.

Naturally, whether we like it or not, all associations are called upon to counsel and refer abortion and I would like to state the stress of the federation is upon prevention of the need for abortion rather than the need of abortion as a method of birth control. The Federation can best be described as a catalyst. With more and more information being published in the newspapers and magazines on the various methods of birth control, it is not unusual to see at the end of an article, "For more information contact the Federation" and with our address.

In the last six months, this has happened in Chatelaine, the United Church Observor, several small town newspapers and twice in Reader's Digest. A January article on vasectomy in Reader's Digest yielded four hundred letters to our office asking not just for information but where they could get this simple operation. The majority of these letters came from small towns where we had few or no contacts. However, we were able to direct these people to where they could get help and as a by-product of this article we received letters from doctors prepared to accept referrals who wanted to be put on our lists.

Since Minister Munro's statement, or announcement, of September 18th last, the Federation has added another dimension to its activities. That is, to assist the federal government and subsequently any other level of government in any way we can to implement the federal government's new policy on family planning. It is our belief that every child should be a wanted child and that access to the information on the number and spacing of one's children is a basic human right. Thank you Mr. Chairman.

Dr. Watkinson -

Thank you very much Mr. Strehler. Well, that's a very helpful run down on the scope and the activities of the Federation. I think, most of all, it perhaps illustrates the fact that here is an organization to which you can turn for a great deal of assistance in addition to what we hope will be available through federal government resources and perhaps certain other resources.

Is there one, at least one, division or branch of the Federation in each province?

Mr. Strehler -

Unfortunately no. Prince Edward Island and Newfoundland do not have branches.

Dr. Watkinson -

Now, what about the Northern Territories? The Yukon or Northwest Territories?

Mr. Strehler -

We have contacts - no official organizations. We have people who are prepared to work should we be able to provide them with resource material. At least, that was the story up to today. Perhaps, now, it will not fall on us to provide this. But we have people very concerned in the area.

If I may make one more comment Mr. Chairman. I think those of us in the Federation certainly welcome the federal statements.

We welcome the provincial activity that has occurred in certain areas. I think however, that, deep within our hearts, we know that the battle is going to be won on the local level. If I may amplify that with one example - I was called into one area of Ontario by an extremely competent medical officer of health who was trying to implement our then Health Minister, Minister Wells' wish that all health units or departments of health offer family planning but was scared of the attitude of the medical profession in the area. This medical officer of health said to me, "I am prepared to put literature into our health units. Could you please scout around and find a voluntary organization to whom I could give the money to run a clinic because I am scared of upsetting the doctors in my area." This is not a unique case and I do find it disturbing.

Dr. Watkinson -

Well, I think we all agree that as far as Canada is generally concerned and certainly from the point of view of official recognition, we are very much at an early stage. I think it is a matter of time before some of these difficulties will be overcome. However, I think the point at the moment is that your Federation offers an extremely helpful service that is available to support directly the efforts of the provincial units or divisions or whatever will be set up ultimately under official government provincial authority.

Mr. Strehler -

I would like to make one more comment, Mr. Chairman, about the ad hoc meeting. Of course, no one knows who is on the Board of our Federation but when the ad hoc meeting was convened and the experts from across the country were invited to attend, it was not coincidental, I think, that every member of the Board of the Federation was invited, not because they were on the Board of the Federation but because they were experts on family planning. I'm talking about people like Serge Mongeau and Dr. MacKenzie here both of them represented on the Board of our Federation.

Mr. Van Der Veen -

I have a question. Can you give me the name of the people that you said have inquired, people from the Yukon, because I'm aware of nothing.

Mr. Strehler -

I will be glad to write you the name of the people who I know to be interested in the area.

Mr. Gaudet -

What is your budget, let's say for the past year?

Mr. Strehler -

Our past year - we are now at the July 1st to June 30 of the budget - approximately $30,000. This gets rather complicated because I am also paid by another group - the Family Planning Education Fund which is again part of the International Planned Parenthood family. Although I hate to say it, in terms of the International Planned Parenthood Federation, Canada is still an underdeveloped country. Therefore, we are scrambling for dollars.

Mr. Palko -

By way of comment and acknowledgement, I would like, on your behalf of the Chairman, Dr. Lennox and myself, to thank Brian and the Federation. They have been extremely helpful in the initial stages of the education - information program, and assisted us in locating varying resources.

Dr. Watkinson -

We would be glad to endorse that very much Mr. Strehler.

Mr. Archibald -

I just have a comment to make concerning an organization like this running on a budget of $30,000. I think it is almost the biggest scandal that I have ever heard of. Considering information we had yesterday about funds available to organizations and so on, I don't know what the difficulty would be, but I'm sure Brian has checked everything else as far as applications for funds and so on.

Mr. Strehler -

Excuse me, Mr. Chairman, may I respond to that? In all fairness, I agree with you that a voluntary agency does have it's own fund raising to do - it is a responsibility of all voluntary agencies. I think one of the problems, perhaps, is that things have moved very fast. As I say, we have been working for seven years; now we are suddenly very respectable and one of the largest problems is to know which direction to go next. I think things will fall into place.

Mr. Knight -

Brian, are any of your affiliates financed in whole or in part by United Community funds?

Mr. Strehler -

This, of course, is up to the local association, Mr. Knight. One or two do receive funds. I believe, Dr. MacKenzie, Vancouver does. I think that Hamilton is receiving it but, of

course, many of our associations were on a charitable status during the last year and we all know United Community funds have become considerably tighter this last year. Some, I believe, had chosen not to apply because they feel they can raise funds elsewhere. This is an individual association decision.

Dr. Watkinson -

Thank you. I wonder if we are ready now to turn to Dr. Brown and ask him to speak more broadly on the Canadian contribution to the International Development of Family Planning.

Dr. Brown -

Thank you very much, Mr. Chairman. May I also thank you for having invited me to talk to this group. I personally feel it is very appropriate to talk about Canada's role internationally at this meeting even though this meeting is focusing on family planning in Canada. Certainly in Ottawa has been seen that our action internationally and our activities within Canada must go together. In fact, the announcement of a policy last September by Mr. Munro was paralleled by a similar announcement on the same day by Mr. Sharp, the Minister of External Affairs, concerning our intention to support population and family planning activities internationally. I think, perhaps, releases regarding the international scene are on the table in the corner there for those who are interested.

Very briefly, the reason behind this is that it was felt that Canada's international aid program was not properly balanced, that it did not pay due concern to the rapid rate of population growth in the developing countries and that developmental support in other sectors, economic and social assistance, would be inadequate if the Canadian International Development Agency did not also concern itself with the problem of rapid population growth.

Just briefly there has been a very dramatic change internationally in the field of family planning. There are now over 25 countries in the developing world that have national policies and national programs, some of them for a good number of years. More recently the United Nations has greatly expanded its activity in the population area. The IPPF that Mr. Strehler mentioned has been active for many years and has been increasing it's role very dramatically. The World Bank has entered into the field. A number of other donor countries, particularly the United States, Sweden, most of the Scandinavian countries, Britain and most certainly Canada are now providing all major aid in the population and family planning field.

Since the announcement of our policy regarding support internationally this fall, we have moved ahead on three levels. First of all, on terms of multi-lateral aid, that is, aid from

Canada to international organizations. CIDA, the Canadian International Development Agency, has contributed 4.25 million dollars to two organizations, the United Nations Fund for Population Activities and the International Planned Parenthood Federation. The U.N. Funds for Populations Activities was formed only three years ago by the Secretary General of the U.N. to support, finance and encourage the actions of various U.N. agencies in the population field. This includes the World Health Organization, UNICEF, UNESCO IALO and the U.N. Population Division itself. This fund is growing very rapidly to a present level this year of 15 million dollars and Canada's contribution to this is quite substantial now. The international Planned Parenthood Federation, grouping all the international and national voluntary agencies, is also operating on a budget about the same level and our contribution is also important there.

In a second broad area, we are also developing, more slowly, bilateral assistance, that is, direct assistance, from Canada or in cooperation between Canada and particular countries. We have completed a project with Ghana; we are investigating projects in four other countries at the present time; we are also supporting training in Canada of students from developing countries who want to further their knowledge in family population planning. I would like to stop at this training point because I think this is extremely relevant to this meeting.

In developing our international program, we are, of necessity, falling back on the resources that exist in Canada, and we very quickly found that the resources in terms of training of skilled personnel in the field of family planning was very limited indeed. This hampers to a great extent what we can do on a bilateral basis. It is one thing to contribute financially to an organization such as the U.N. but it is another matter indeed to try to provide more practical, shall I say grass roots, kind of support internationally, and training is perhaps the most striking example of this. We are working with Dr. Mongeau's group to provide training for Francophone Africans, as Mr. Strehler mentioned. We would like very much to do something of a similar nature for English speaking students. We are talking with various universities about this at the present time. We are also supporting demographic training and again to francophone students at the University of Montreal. It is very clear that training of students coming from abroad does not make much sense unless there is something going on in Canada in which they can participate or observe or get practical experience. Therefore, in this sense, our international efforts are very much dependent on the kind of training and other resources that exist in Canada and are developed here. Until we develop training programs for Canadians and service and research programs for Canadians, our international efforts are bound to be limited.

The third broad area of interest I mentioned earlier this morning is research and this particular area has been in the concern of the International Development Research Centre and this

program is just getting under way. I think my early remarks are sufficient. This is a very quick view of what we are doing internationally.

There is one other area that I wanted to talk about this morning partially coming out of what Brian Strehler had to say. I think we have quite a bit to learn from what happens in countries, not only the developing countries but the other developed countries. I suggest that, at this time, when we are really just beginning to get deeply involved in, or in the process of evolving, family planning and population activities in Canada, we could benefit from association with similar programs in other countries. We could perhaps learn from the aspects of those programs that worked and avoid the mistakes that certainly were made in other areas towards developing more effective programs here. As a general review I want to pick out two or three things that seem to me of particular relevance to the discussions we have had here. These are certainly features of programs in other countries and I am not suggesting that they are automatically transferable to Canada but I do think that they might offer some food for thought and discussion.

In establishing programs, we naturally start with objectives. In moving on from objectives, the question of the finding of the need (what is the need for family planning in Canada) is an area of crucial importance which in my view has been neglected up to the present time. In many countries, even most countries involved in the family planning field, there have been a number of studies and analyses to try and determine what are the areas of need, what are the populations at risk, to define this more clearly, first of all to focus more clearly what the practical objectives are. I think the objectives that have been outlined here are very broad ones, very basic principles.

Moving from basic priciples, we need more principal, if you like, operational objectives and to get these we need a more clear definition of the need. I have broken these down into two areas. First of all there is the express need as expressed by respondence to large scale sample surveys of the KAP type - the knowledge, attitude and practice of family planning. These surveys have been done in over 30 countries around the world now, many of them repeatedly. In virtually every case, they have demonstrated that married couples and individuals want to have fewer children than they actually are having and family planning services are desired and wanted. These are expressed on the basis of interviews and are not usually transferable into a prediction of how many people will come to a clinic once you open it. None the less, they are important expressions of latent interest and desire and need in family planning.

One of the most striking analyses, in this area, was

recently made in the United States and unfortunately we are all too reliant on statistics from studies from the U.S. This particular one was a very careful study of unwanted pregnancies that occurred over the last decade. It concluded that for the year 1966, the last year of the study on studies and reference, fully 20% of all the pregnancies in the U.S. were unwanted pregnancies. Now, 20% is, to me, an incredibly high statistic and does not include merely the socio-economic groups or the minority groups but this is, by-and-large, a large number of middle-class Americans who are having unwanted or unplanned pregnancies. We have no comparable statistics here in Canada. The one major study I referred to yesterday, the one in Metropolitan Toronto, suggests that similar investigations here would not be that much different. That is a very inadequate kind of a statement because we really do not know but I think that it is possible that, at least in urban U.S. and urban Canada, we would find similar results as the U.S. survey I mentioned.

That is one kind of need, the expressed need. The second is the need as it is manifested by particular actions of the population concerned and these include illegitimacy, abortion - legal or illegal - abandonment, child neglect, battered babies and social dependency. Now, many of the things can be quantified and indeed are quantified in Canada but are often only rarely related to the need for family planning services. I think this is the kind of information that could be, at least in some communities, very easily pooled to demonstrate what is the need as manifested by people who have had unwanted pregnancies in different communities. Of course, there will be differences across Canada.

The third area is mortality, particularly infant mortality and morbidity resulting from prematurity, and secondly, maternal mortality, as Dr. Lennox mentioned earlier. This kind of more specific definition of the need can then lead to more specifics of the target populations and groups at risk to which specialized programs can be developed. Again, I think it is important that this kind of study be considered in different areas because the kinds of groups and target populations exist in different areas and must be identified.

This leads to the development of services. I have just one or two remarks here. Of course, the development of services is a very broad and a very large field that I would not want to try and cover here. There are just two or three principles that have come out of experience in several countries. One has been stated yesterday that the services must be suited to the behaviour patterns and actions of the groups at risk. It has been very clearly shown that the opening of family clinics in hospitals or health centres is not adequate. This only touches a small percentage of the population, the population that comes to the clinic anyway. Much more must be done to develop programs that are more suited to the needs of the people.

As a corollary of this, the most successful programs are those that have gone into the community and developed community services of one kind or another. This has been done through existing community personnel such as public health nurses, social workers, or through the development of more specialized workers through the community-family planning contact workers who can specifically go and reach those families who are most at risk.

There is obvious advantage through associating family planning with maternal and child health services. Perhaps the most successful single special program has been the so-called "post-partum" program. It has been developed now in many countries, both developed and developing, in which family planning information and services are associated with delivery care in hospitals, that is pre-natal care, delivery in maternity wards and post-partum care. The philosophy here is, of course, that women and men are most interested and concerned at this time about the question of a subsequent birth or family planning and are most receptive to information. This has been borne out by the experience in many countries developing family planning as part of maternity care. It also has a very important additional benefit of, first of all, improving post-partum services per se, just by themselves, then having important relationships in terms of reducing infant mortality, maternal mortality and prematurity.

Finally, on evaluation-I think evaluation is essential but we must think about it at the onset - what we're going to evaluate and how we're going to do it. Evaluation, of course, refers back to a careful definition of working operational objectives, if they are clearly defined, and one can measure the effects, or lack of them, by the program over a period of time. As one nice example of effective evaluation, I just wanted to read parts of a press clipping from yesterday's New York Times which was rather pertinent to at least one part of the evaluation. This is a report from New York City on the decreased infant mortality rate in 1970 as reported by the Health Department. In 1970, the infant mortality rate was 21.8 per 1,000, a decrease of 5.6% from the 23 per 1,000 in 1968. Possible reasons for decline, according to the Deputy Health Commissioner, were extended family programs, improved pre-natal and post-natal care, an overall improvement in the general health of the population and a decrease for pre-mature births of the year. The article goes on to say that the infants whose mother received no pre-natal care faced a mortality rate four times greater than those whose mother did get such care. An important factor in improved pre-natal care was the availability of family planning services. New York City's record low was attributed by the Health Department to the work of its maternal and infant care family planning project. Dr. Daly who heads this federally-financed project considers it had enabled many women to prevent unwanted high risk pregnancies - women, for

example, who are in poor health or have given birth recently. The project has 22 clinics throughout the city which have a total of 67,000 visits each year.

I just read that as one specific kind of evaluation which I think stems from an operational objective of that particular program. This is a very large field and I have only touched on a few small points but I do feel that there are some interesting things that could be studied. Possibly some apply to the situation in Canada. Thank you.

Dr. Watkinson -

Thank you very much, Dr. Brown. I think that you have made a number of very useful points and, in fact, this is a most valuable contribution to this meeting. It can be very helpful to many of us. Before opening up your presentation for questions, you mentioned the benefit that can be derived from consulting with other countries who are developing or, in fact, have developed, similar programs. Have you any countries in mind? Which countries would, you think, have moved the furthest along this road?

Dr. Brown -

I suppose two obvious examples would be the U.S. and Britain. Britain particularly has had an extensive program for some time - very largely initiated by the Family Planning Association of Great Britain and more recently the British Health Services have moved in in a large way - and the U.S. Also it is the voluntary groups who have led the way but more recently the U.S. government, at least, is attempting to appropriate very large sums for family planning nationally. Those are two obvious programs. I think there is a great deal to be learned there, to echo Mr. Strehler's remark. I think there is a lot to be learned from the developing countries as well. They have further to go than most of the Western world in defining their government policies. This, of course, is partly because they have had a much more dramatic need in terms of very rapid population growth but on the other hand they have been forced to the wall in getting to this point. They've gone through some very difficult decisions on the policy making way and I think there is great deal to be learned from large programs such as India's and Pakistan's.

Dr. Watkinson -

Yes, thank you. Questions?

Mr. Archibald -

In relation to what other countries are doing, I came across some startling statistics in the publication from the Planned

Parenthood Association regarding Hong Kong's program where 20 volunteers visited over 300,000 women in one year. That's 15,000 visits per worker. I wrote it down from there, I don't know anything else about it.

Dr. Brown -

I wonder if there is a digit missing somewhere. However, Hong Kong's program is one of the world's most successful. There has been a dramatic decline in the birth rate there, largely due to the work of the family planning association and that in turn is due largely to their field work and their community oriented program. I don't know how they could visit that many either.

Speaker - Mr. Strehler -

One of the interesting things about Hong Kong and places like Barbados, which has also had a dramatic decrease in its growth rate, is the fact that the smaller the area the easier the communications and what we are talking about basically is communication. This is where you can see some very dramatic results in small areas. I would just like to add one thing more and that is, we have again to thank Dr. Brown or the Canadian Government for the very generous donation to the International Planned Parenthood Federation. If anyone is wondering why the Canadian government would, on the same day, announce grants to the U.N.F.P.A. and to the IPPF, I would point out that the very nature of our being a voluntary agency makes it possible for us to go into countries where it is totally impossible for specialized agencies of the United Nations, for example, because of the political overtones. As we all know, there is a great degree of sensitivity surrounding family planning, especially with regard to the developing or the developed countries. Therefore, this is where we are very fortunate to be able to get in often when no one else can and set up the ground work that is often picked up later by the governments and then U.N. agencies and so on.

Dr. Khazen -

Can you tell us, Dr. Brown, where are the training centres in Canada, or maybe Brian can answer this question for us- training centres for nurses or social workers in family planning?

Mr. Strehler -

The point is, I think, while there are a few existing, there are a number of potential areas. The most important existing one is Dr. Mongeau's centre in Montreal which trains nurses, social workers and other people as part of its basic functions. I don't think there is anything as well structured elsewhere. There are a number of hospital clinics in various cities in Toronto, Vancouver, Winnipeg and so on, where practical training is possible within

the framework of a family planning clinic.

Speaker -

Not other than to say quite a few people still go down to the United States for training.

Dr. Khazen -

I know, but sometimes they felt it is still different in the United States. We want something in Canada.

Speaker -

I think it is one of the priorities to set up somewhere in Canada where people can be trained, is that not right?

Speaker -

I think also there is some interest in schools of social work and faculties of medicine. I know Dr. MacKenzie is interested in this in B.C. Again, reflecting the fact this is a very new field, at least officially, there are a number of possibilities but very few existing facilities.

Dr. Watkinson -

Dr. MacKenzie, would you like to comment on this?

Dr. MacKenzie -

I think when you talk about training, you have to determine the sort of training you mean. To have a person well versed in all aspects of family planning is a rather difficult affair. For example, last year in our clinics, we trained about 83 nurses in some relatively simple techniques and then let them become familiar with a slightly specialized type of interview. We didn't go into much in the way of demographic considerations or anything of this sort. If a physician wants to learn how to put in an I.U.D. he can come to our clinics and we arrange a number of them for him and we watch him do them and help him with it. What we do lack is a comprehensive unit, or units other than Dr. Mongeau's, in the whole area of multi-discipline approach to family planning. Right now if you need to learn a technique or to get some experience in special types of interviews, it is pretty widely available through hospital clinics who have family planning clinics in the community.

Mr. Knight -

Mr. Chairman, I would just like to add a bit about schools of social work. There are no courses in schools of social work, at the present time, related to family planning and the only field work facilities that are operating, to my knowledge, are two or three students placed by the McMaster school, in the

Hamilton clinic of the Hamilton Family Planning Association. There are also a couple of students from the University of Calgary in an experimental school set up for pregnant teen-age mothers in Calgary.

PROVINCIAL PROGRAMS AND ACTIVITIES

Dr. MacKenzie -

Thank you Mr. Chairman. As you have said, I can probably describe what seems to be going on in British Columbia. I can, at least, give you the provincial policy as I understand it but this may not in fact be the provincial policy.

In British Columbia at the present time, in the field of health, there is now a definite trend and intention of making family planning services available through the public health agencies. I don't know exactly what the stand of the welfare side is at the present time. There has been in the past some very advanced thinking in this area, particularly in the area of child welfare. The actual activities in family planning and with clinics are quite extensive in British Columbia. I've just been adding them up and there are at least twelve public clinics functioning. Eight of these are in Victoria and the lower mainland and are operated by the Family Planning Association, a private society. This private society is in close association with the official health agencies at the municipal and provincial level and, in fact, receives some of its financing from the province by periodic grants, usually just shortly before the society faces bankruptcy.

There are also other official subsidies to the Family Planning Association's clinics in that these clinics are usually housed either in a health unit building or a neighbourhood house or something of this sort. In the case of the rather large clinic in the city of Victoria, the medical practitioners acting in that clinic are paid by the municipality of Victoria. I don't know whether Victoria recovers any of these monies from some other level of higher government. The rest of the people working in that clinic are, of course, volunteers.

In the city of Vancouver a very small amount of money, and we are phasing this out I think over the next two or three years, comes to the Family Planning Association from the United Community Services.

As I've said, there were twelve clinics working in British Columbia. Two of these are frankly provincial health unit clinics. The Family Planning Association has been of some assistance to them in that we've put up some money for advertising which was not included in their budgets. The clinic at Prince

George is operated by the Union Board of Health for that area and was set up to face the rather special problems of that city with a lot of migrant workers and things of this sort. There is a clinic in the city or Kamloops, operated within the hospital by a number of doctors there and is more a hospital-based type of clinic with both public support and provincial monies.

All the other birth control clinics are Family Planning Association primarily and subsidized by the province - sometimes by the local municipality. The volume of people going through these clinics is quite considerable. I imagine that, last year, we had four thousand women go through the main downtown Vancouver clinics alone. They are into their eighth year now. The other clinics are, in the main, a year or slightly more old. It's all fairly new and this sudden growth has thrown us into a financial crisis.

The organization of the clinics is pretty much along the pattern set by the Family Planning Association and is relatively simple with interview personnel who may be welfare worker trained or public health nurse trained. Again, the clinician and the nurse working with him are pretty much technicians and most of the counselling is done either by public health nurses or welfare workers in the clinic arrangement.

There are a number of special problem areas where the province has been active. We have a large number of young people, migrants coming and going, living in communal arrangements and such. These present a special problem and through the venereal disease control program they have been reached by nurses who melt into this sub-culture and, of course, are concerned with a lot more than venereal disease. They are put there mainly for birth control. They deal with the birth control problem in whatever setting seems necessary. They also deal with a variety of other unpleasant little things like crab bites and pneumonia and what not. They also have a number of skid row situations involving a number of drifter women, and for a number of years the province has provided, usually IUDs, to this particular group. They are gynaecologically active in that they are viewed about every three months and usually treated so it is an excellent opportunity to add birth control services to them. The acceptance rate there of any method is about fifty per cent of these women. This is now an entirely provincial program.

In the areas of training, this is again largely the Family Planning Association. Through our clinics last year, I think if I remember rightly, 83 nurses were trained in relatively simple techniques - not a deep extensive training - and a number of physicians visited these clinics for experience. There are seven clinics in the Vancouver area but the three big ones in the Vanvouver General Hospital are manned entirely by the

house staff of the hospital. They therefore represent a training resource for both physicians, nurses and others.

The other activity which is becoming very important is not clinic work but a general sort of education program. This is largely, but not entirely, dealt with by the Family Planning Association. First of all, the Family Planning Association decided that it would go to people who would be delivering services rather than directly to the public. In this way it has acted as a catalyst over the last several years for various courses and meetings, of nurses, social workers, and correction institutions. It has also, in conjunction with the university, put on courses and is about to put one on this spring for physicians and nurses to bring them up to date on birth control, before and after the fact, in the areas of ordinary birth control, as well as sterilization and abortion. More recently we have had considerable pressures on us to go directly to the public and this we have been doing. We have always made speeches at service clubs and things of this sort, but now we have great and urgent requests to enter the schools and to give information in the school setting. This we are doing. We prefer to have this in an ongoing context of family life education or social studies or something of that sort. Our approach here is one of two methods. It is either in the family life education field, where we are talking about birth control from a fairly personal point of view, or sometimes it's from the demographic social point of view, where we were talking about well-population and its potential control. We have a core of speakers and have trained three nurses to give a fairly routine talk on birth control and matters pertaining to it. We have done some work with the media. We have got the odd clip and spot on television and on radio and things of this sort. We do not particularly want to advertise the clinics because the product is already selling one hundred per cent. We cannot take any more people, so we don't, particularly, wish to drum up more business for the clinic. We know we are not reaching certain people and one of our biggest failings so far, we do not have a particularly good follow-up. We realize this is important. We've done studies on this and find that giving information in certain social economic groups is great, and you get acceptance; the follow-up you must provide is difficult and expensive. We have tried to stimulate public health nurses and others to do this follow-up and this is happening here and there. So I think that when the provincial health and welfare agencies come into it more firmly, this will be an important area they can pursue.

We have, and will be submitting in the immediate future, plans for a year's program of media saturation across the whole province. This is not quite as easy as hiring a firm of public relations people running it, because the impact on the services, and on the people, should be measured and it is a complex and very large undertaking. We now have an ad hoc group of citizens prepared to act and assist in putting this program forward.

In research, the province itself is doing some investigative inquiries on how to get services to the people. There is considerable amount of research going on, not particularly at the official provincial level or at the Family Planning Association level, but at the university level using the facilities of the Family Planning Association. Family Planning Association clinics are also used and have taken part in a considerable number of clinical trials on uses of IUDs. We're now doing a clinical trial of the Dalkon shield. We were on a large one with the Lippes' loop. The province, itself, will probably get into this when there are more clinics but has not, as far as I know, done much work of this type. An area in which the province commits itself heavily in the hospital now is, of course, abortion. In Vancouver last month in the Vancouver General, they did about 200 abortions. I think another hospital did about the same number and I'm sure there are quite a few at the Royal Columbian. This is just in one area and I think Victoria does the same. At the moment, I think, we have a very high number of abortions going through our hospitals and these cost money and take up services. We are also beginning to get people back for a second time and people are beginning to panic that maybe we are not just doing the odd abortion. We are going to get into the area of performing quarterly uterine maintenance on some women so that one of the things, which we think will be of assistance in this, is a move in major clinics of our family planning to the hospital adjacent to where the abortions occur. We are getting these two together and perhaps we can make it a little less necessary for the province to set up a special day surgery hospital which they are anticipating. In general, and to sum up what is happening in British Columbia, there is a very close association between the province, the Family Planning Association, (which is at the moment the largest purveyor of information, education and clinical services) and the provincial health branch. The policy of both the Family Planning Association and the provincial government is for the Family Planning Association to phase out of clinic service work. I don't see this happening rapidly but we are agreed that this should happen. The Family Planning Association would then be like other societies free to go on into various other areas which we have shown to work quite well - clinic services, special types of approaches to special groups, domiciliary care or domiciliary programs and either mobile or travelling clinic arrangements. These sorts of things are proving that they work and there is no reason now why the official tax-supported services should not take these over and run them and expand them. There are a few things we don't know yet. We don't know how small a municipality or town or area can support, and needs to support, a clinic. Of course, a very small number of people get this type of service from a public clinic. The great bulk of the birth control information in our province is provided by the practitioner to his patients.

Thank you very much, Mr. Chairman.

Dr. Watkinson -

Thank you Dr. MacKenzie. This is very helpful. Do I understand that the Family Planning Association in British Columbia is an active component of the Canadian Federation?

Dr. MacKenzie -

Yes, we are one of the federates in the federation and the way we have done it is to have a provincial association which is in the Federation. That's the way we've done it.

Dr. Watkinson -

Do I gather from you, then, there seems to be both a recognition and acceptance of the role of the voluntary agency? You mentioned about the association withdrawing from the clinics in favour of the official agency, but I take it that there is a clear recognition of the help given by the voluntary association?

Dr. MacKenzie -

Well, we think so. It seems unfortunate to tie down a relatively small number of volunteer citizens to run a routine service. Although we seem all agreed that this should go to the public side, nothing has happened in this line particularly, but we hope it will in the next few years.

Dr. Watkinson -

I think I'm going to suggest that we move right ahead because I think it is very helpful to get the total picture and if we stop for too much discussion between we may lose the continuity. Dr. MacKenzie, you have emphasized the health side. I wonder whether Mr. Knight or Dr. Splane or anyone else can give us a picture regarding the welfare activities.

Dr. Splane -

I don't think we should at this point, Dr. Watkinson. I would like to ask if Dr. MacKenzie, in two sentences or so, can refer to what he mentioned as the rather imaginative work being done in relation to child welfare. Is this the Don Bingham study, Dr. MacKenzie?

Dr. MacKenzie -

That is the study. It was a piece of social thinking rather than social action. Social action is taking place in that virtually since our earliest clinic started, the child welfare agencies have been very good customers. We have had poor referrals from any other social branch but, on the part of the social welfare organization interested in children, we have had good referrals. The other area where we work pretty closely is with corrections,

both as an educational program among some of the women in their industrial schools and actual service. They will bring people to us. The other area which is very active and where we work pretty closely is what you might call private welfare associations interested in the welfare of women and single girls. We get young women brought to us and one thing we are very careful of, in that clinic, is to give anybody service under any circumstances. We don't want to see anybody being pushed into something they don't want to get into. Occasionally we see one of these. Here we will call upon something like say the Y.W.C.A. who have been of great help in carrying through with rather lengthy counselling and such in cases of that sort, so that we're tied in. The whole thing is tied together. It is very difficult to say who is doing what, everybody is into it pretty well.

Dr. Watkinson -

Thank you very much. I would like to move on to Alberta.

Mr. Matheson -

Since 1969 two family planning clinics have operated in Alberta, one situated in Edmonton, the other in Calgary. These are funded through the Preventive Social Services of the Department of Social Development and the City Health Departments. While the two major cities have established the only formal family planning centres, they do represent a service to a potential one half the population of the province. Clinics are held one evening a week, with between 20 and 25 persons attending. A gynaecologist is in attendance to give physical examinations, pelvic examinations and cervical smears. Three public health nurses are situated in the Edmonton clinic where they compile histories and maintain counselling services and assist the physicians. In the Calgary clinic one public health nurse, a social worker and a receptionist are present at all times. The social worker takes the history, discusses methods and techniques of birth control and refers patients to other agencies where necessary for other problems. Supplies of birth pills are provided free to many patients, where indicated, while others are provided with appropriate prescriptions. Attempts are being made presently to reach the Indian Metis populations that are situated in these two cities, and others who are not likely to go to a private physician. Single girls are accepted by both clinics without reservation.

In 1970 a conference was conducted on family planning using the city of Calgary model. This was attended by persons from a wide range of agencies and disciplines. In the smaller community areas medical officers of health and public health nurses engage in more informal family planning programs. Up to the present this has been a preparedness on the part of the health unit - to encourage interested and concerned persons to discuss family planning and enter into family planning and counselling with referral to their own physicians often facilitated. A primary difficulty encountered in establishing more formalized and comprehensive services

in smaller communities is the absence of gynaecological back-up service, since these are mainly situated in the two large cities. A secondary contributing factor, with the possible exception of the medical officer of health, has been a feeling of insecurity among health services personnel since they are not, as yet, as knowledgeable and conversant with technical details and approaches as they would like. Towards the resolvement of both these factors, the health education branch of the Alberta Health Department, in co-operation with the local health units and other health agencies, propose the planning of regional conferences and workshops during the current year. These will be aimed at involving a more uniform level of technical and emotional comfort among public health personnel and those of other agencies within the smaller communities of the province. In further support of this, literature and other printed material has presently been reviewed in order to satisfy two major objectives - that of in-service training and public information.

Now, Mr. Chairman, I find it rather difficult to respond to some of the questions you had asked us to comment on in our province. As you may know, Bill 50 is presently before the legislature and, if enacted as I have no doubt it will be, will provide for the amalgamation of the health and social development departments. There has been no declared, enunciated policy insofar as family planning from the government level. I can say this, the principle is well established and entrenched. I visualize that once this rather grey period we are going through now is over, that a task force or some similar vehicle will be established, probably within the two departments or the two elements of what will be the same department, to engage and co ordinate, probably at the conference level to begin with, the voluntary agencies and other elements within the communities presently grappling with this particular problem. Stemming from that, I would think that, probably, regional vehicles will be established, possibly under the composite board concept, that is provided for in the new Bill whereby a number of responsibilities, a number of services already existing indigenous to the community, are brought under a composite Board including the two health units, the Department of Social Development offices, hospitals and a number of others. This is looking forward I would say to a minimum of two years before this particular concept starts to take hold. If I find it difficult to respond explicitly to your questions, these are some of the reasons.

Dr. Watkinson -

Thank you Mr. Matheson. This is a good beginning. Can we turn to Mr. Archibald right away to complete the picture?

Mr. Archibald -

First of all, I feel slightly hypocritical in talking about family planning having had two children in just over two

years but they say that one school of thought says that it is the third child that is the real problem. Maybe there is some hope yet.

The social allowance portion, or the public assistance portion, of our department is presently purchasing a minimum of $50,000 worth of contraceptives annually on behalf of public assistance recipients. This is a minimal figure calculated on the random sampling type of survey. There is no official type of training being done for social workers at all in the area of family planning except in the case Jack referred to with seminars put on by drug companies.

Besides this more or less traditional aspect of our department, I would like to refer briefly to a program that Jack alluded to, the Preventive Social Services program. Here we can see some real beginning in the field of family planning. Basically it is a concept of meeting needs before they become acute problems or of finding methods whereby individuals might draw upon local community resources at the very early stages of need. This early intervention would pre-curb further individual and family breakdown and ultimate dependency on public aid. The results of the explorations done in the province have led to the Preventive Social Services Act being passed in 1966 in our province. The entire idea of the Preventive Social Services Act is that it allows local municipalities to enter into the program with our minister, at their request, so it is a free piece of legislation. If they do wish to enter into the program, there are two conditions - number 1, that they sign this agreement with the Minister and number 2, that they hire a director that is locally appointed who is not a provincial employee.

Now, any programs they get involved with, on the local level, involve money, at least most of them do. We pay 80% of the costs of these programs. The local municipality will pay 20%. The directors work with advisory committees and, together, they examine the local needs and resources of the area. To date, we have approximately 120 projects approved on this 80% - 20% basis amounting to 2.6 million dollars. There are another additional 200 programs that are non-funded, or volunteer programs, involving another 10,000 people. So we borrow to an extent from the public health concept, prevention being primary, secondary and tertiary stages.

Out of these programs are emerging considerable interest in family life education and an outshoot of that would be family planning. The two clinics that we have in Edmonton and Calgary average $20,000 a year. The Calgary clinic has a rotating team of social workers going through; the one in Edmonton has a rotation of volunteers going through. Together, the clinics have seen about 700 people during the past year. The liaison between the social workers and the health unit nurses is fantastic, I think a moral for other communities and provinces to follow. Seventy per cent of the clientele that are coming into the clinics receive their supplies free and the ratio of patients has been approximately 50% married to 50% unmarried.

The one concept that I'm pretty happy about with the clinics is that they are beginning to serve as the training ground for doctors, nurses and social workers who rotate to some degree. Perhaps we have gone a little bit too far on this, not keeping enough of a corps group that Serge was talking about yesterday, people that clients can see regularly when they come back for a follow-up visit. The referral system is working out very well especially with the nurses in Calgary. This last year there have been 1600 home visits made where family planning was discussed with clients. I have no statistics with regard to the work of social workers and I don't think it's nearly that high.

The quality of our intake is another good aspect of the problem. We utilize the concept that Serge was talking about, where a social worker or a nurse spends almost an hour with the client discussing the whole field of their behaviour in a non-judgemental way. As you appreciate, there have been many referrals to psychiatrists, psychologists, specific social workers and so on, as a result of this. The problems where the kinks are lie in the fact that no real outreach is being done outside of the limited advertising and referral systems. They are scared out of their minds to publically advertise it for political reasons. The challenge of these clinics, as I see it, is to expand. They can expand to utilize a lot more volunteers to make indigenous efforts to meet isolated groups, to utilize more home visits and work extensively with and at hospitals, the post-partum thing Dr. Brown referred to, as well as to expand their training facilities to help other agencies and communities.

Our difficulty with this comprehensive plan is hardly that of funds. Some of our other programs are involved in family planning and are in the educational referral system primarily. Here I'm speaking of family life education groups which, at times, set up on this type of work with a special group such as the prisoners.

Home visiting and counselling services operate the same types of referral systems. I think the plan right now is to emphasize that people attending family planning clinics will be looked upon as total human beings where a number of needs could be met instead of upon each person walking through the doors as automatically having a contraceptive problem. I think this philosophy depends upon that of the funding agency, the director and the intake workers primarily. It was very gratifying to hear Serge's emphasis on that point also. We also believe that, wherever possible, these clinics should not be directed or run by the government but by local citizen groups and private agencies. We see the role of government as being more of consultation and funding.

Our abortion rate is going up considerably - last year, according to various sources of information, 3,000 abortions in the province, which is a much higher portion than Great Britain. Everybody is referring to the great number of abortions in Great Britain and yet, per capita, they have fewer than Alberta. We would have 1,800 abortions per year if we had the same ratio of statistics as Britain instead of our 3,000. We are concerned about abortion being a method of birth control and if we had the same ratio of statistics as Japan with its abortion figures, we would have 105,000 abortions a year, almost our birth rate.

As I see it, the federal government's role is mainly, besides funding, to provide consultation for existing government and private personnel involved in family planning and setting a team of federal agents to help government and private agency officials plan effective services. I can see a real possibility resulting from the federal government sponsoring initial training courses of a very intense nature for various provincial and agency people after which they can continue this training back home in their own locales. Also, the formation of a policy booklet on how to obtain funds - the various things we had yesterday. This could somehow be combined to send out to these key people to whom Dr. Watkinson referred. I think it would be most helpful if a co-ordinated effort was made in this regard. Also, I can see the federal government helping provincial and private agencies with regards to films and booklets - we talked about this a bit yesterday.

Some other areas that you may want to look at would be families who could benefit from the service - this motivation aspect again. Films and books directed to single persons, too, can help - also, films and books dealing with motivation of para-professionals and methods they can use in their role in family planning. I can't see where we are ever going to get a system where we would have one, such as Britain, unless we get into this area very heavily with para-professionals and volunteer groups.

There is no official stand as far as the government is concerned. Our Minister has signed the agreement with the Edmonton and Calgary cities, the family planning clinics, so that could be looked upon as an endorsement of those clinics. However, it has never reached Cabinet and there is no policy regarding social workers although the feeling in the department is, you know, let's move ahead very fast, and with the decentralization that we're going to expand with the Health and Welfare merger. I can see here that there will also be a certain expansion within the planning. Thank you.

Dr. Watkinson -

Very good, Mr. Archibald. I noted that our federal members here at the table have jotted down your suggestions

regarding what the federal government might do, I think that's very helpful.

Mr. Huesing -

Ladies and Gentlemen: - Representing and speaking on behalf of such a small portion of the Canadian population I will admit that I feel a little bit like a tadpole in a pond full of bullfrogs. Although our population is small and our government is a young one, our problems certainly are not. In fact, at this meeting it is difficult to imagine our being concerned with family planning where we are dealing with or talking about a territory which has an area of 1,300,000 square miles and a population of 32,000 people. Over-population is certainly not one of our problems.

We in the Territories, however, are actively concerned with family planning programs. The reasons for our concern differ somewhat, I suppose, from those of our provincial compatriots in that we are concerned, perhaps disproportionately so, with the people problem rather than the problems associated with influencing economic factors. In the past 20 years or so the size of the family group has rapidly increased in the Territories, particularly among our Eskimo people in hitherto inaccessible areas.

The impact of these large family units is brought home to us every year in terms of infant mortality rates. In 1969, for example, infant mortality in the Northwest Territories averaged at 53.7 per 1,000. This figure, in itself, is enough for us to be concerned, particularly when this average is related to the indigenous and other segments of our population. We find that the average is composed of 20.5 per 1,000 for Metis and White, 24.2 per 1,000 for Treaty-Indians and 90.5 per 1,000 for Eskimos. The obvious question then comes to bear, why the astronomical difference of mortality rates between Eskimo and other segments of our population? There are many contributing factors, of course, some due to the geographical differences which relate directly to differences in the harshness of the climate and the availability of foodstuffs found on the land and their related influence on diet. The most dominating factor, however, is that Indian peoples have had, for over half a century, some form of medical aid and counselling available - initially, through the missions which followed the fur trading posts along the MacKenzie River System and other natural water communication systems, and later with the establishment of nursing stations and hospitals. In contrast, some settlements of the deep Arctic have not had ready access to these facilities until the last decade. The availability of the facilities has had an impact in that further analyses of the mortality statistics reveal that there is no similarly disproportionate variance in mortality rates per neo-natal infants between these groups, the average of neo-natal mortality being some 22.7 per 1,000. It is a well known fact that there is a high rate of

premature infants among women who conceive children annually. It is also a well known fact that in large families where the children are close together in age, there is a disproportionate incidence of respiratory disease, particularly in a harsh climate.

In context let us examine the causes of post neo-natal deaths among our Eskimo people and why family planning is a necessity in order to resolve the resulting problems. Several decades ago, prior to the advent of readily available medical assistance, individual Eskimo families were not large ones. Natural causes, both in the neo-natal and post-natal period, took an extremely heavy toll in that nature was the family planner. With the arrival of the "southern culture" and modern medicine, the deliveries took place in hospitals rather than in the tents of the summer camps and the igloo of the winter camps. This caused a significant decrease in neo-natal mortality and a subsequent increase in the size of the family group.

This influx also resulted in a significant change in the day-to-day life style of these people. They had been provided with most of our modern means and ideas but had not absorbed the exposure to the training which goes along with utilizing these means. A simple example of this is a trend or change from breast to bottle-feeding. The means is catching on but the training in terms of sterilization of bottles and ensuring that the bottled milk is properly prepared has not; the result, a high proportion of post neo-natal deaths due to gastro-intestinal infections. Similarly, because of a large number of children with low differences in age, a significant proportion of the death rate is due to respiratory illnesses.

Because our people are so few in number and spread throughout such a very vast area, it has not been possible to bring about a forceful family planning program. Other significant contributory factors - language barriers and the predominant cultural differences in that the cultures of southern Canada have been practising, if not on an organized basis, at least on an individual basis, some form of family planning for some time. The approach which the Territories has taken to family planning is predominantly one of information and making both the mechanical and pharmaceutical means of birth control readily available to all segments of our population. Similarly, surgical means such as tubal ligation and vasectomies have been made available. Also, in places where we have them, pre and post-natal classes sponsored by the Public Health authorities now embrace family planning concepts and practices. There is however no formal family planning program but the idea is catching on. In one of our communities a volunteer group is now organizing to provide family planning services and some assistance for this group in terms of training etc. will be sponsored under the auspices of our government.

Our concern and interest in family planning is not just due to the mortality rates of the infants. A very important psychological and economical factor must also be considered in that the family head can no longer support his family by his own skill but rather is dependent for that support on the availability of work and money. This factor is one for which our indigenous people are presently neither psychologically, culturally or economically prepared. Because of these major social, medical and psychological problems, the counsellors of the Northwest Territories, as well as their public health authorities, are actively interested in promoting the family planning concept throughout the Territories and certainly support any national program of this nature.

Mr. Chairman, in regard to these specific queries that you asked us to remark on, as you probably know, I was very interested in my friend from Alberta's remark that one of their goals is to have a clinic for 50,000 people; that would not give us one clinic. The disproportionate disadvantage that we have in terms of setting up clinics where you're dealing with communities of 50, 75, 100, 150, 200 people is fantastic. You talked about social work - public health - authority liaison - how can you talk about liaison when you are lucky to have one or two public health nurses in one community where she is also the dispenser of social assistance, the public health nurse, the doctor, the priest and everything else that goes along with it? So our problems are so disproportionately different, I think, even from the Yukon, that it is very difficult to answer your questions in the same context as another province could.

Dr. Watkinson -

Thank you Mr. Huesing. Your points are well made. At the same time I hope these presentations and discussions will be of value. Some of the principles may be useful to you and to your colleagues.

Mr. Huesing -

Yes indeed, they are in fact providing some sort of assistance. This is why I say our program is not a forceful one but it is there - it is subtle.

Dr. Watkinson -

Could we move now to the Yukon and invite Miss Nolde or Mr. Van Der Veen to speak?

Miss Nolde -

Family Planning in the Yukon is very similar to that in the Northwest Territories in that it is not an organized

service. In the Yukon, the policy of the Department of National Health and Welfare is followed which states that information regarding family planning is available to those people who are interested in it and who request it. There are no organized family planning clinics. In the whole territory of the Yukon there are 18 private practitioners who are supplying all family planning information and services. Eleven of those private practitioners are situated in Whitehorse. The referrals are sent to the doctors from public health nurses, community aids and community health workers. The only settlement in the Arctic is Old Crow and this is serviced by Inuvik in the Northwest Territories. Other areas having small hospitals are Mayo on Watson Lake and, of course, Whitehorse is the largest area. The same problem exists as in the Northwest Territories. Over-population is not the main issue, as the country is twice the size of Great Britain and the total population is only twenty thousand. Ten thousand of those people are living in Whitehorse. There are no Eskimoes. Old Crow is an Indian settlement. The Indian population is not very high. There are two thousand, I believe, in Whitehorse in proportion to eight thousand whites.

I can't really comment with regards to the needs for the future. Family Planning priority doesn't seem to be very high under the present policy because the information is only given to those people who request it.

I think that's all I have to say.

Chairman -

Thank you very much, Miss Nolde. I think you have brought out very well that you share many of the same difficulties that Mr. Huesing referred to. I think here too that we'll have to do what we can, working closely with the Medical Services Branch, and with the governments in the north, to meet these very special needs.

Now, Mr. Van Der Veen, were you going to add to this?

Mr. Van Der Veen -

Perhaps, very briefly, Mr. Chairman. The child welfare program in the Yukon, while the population is small, is still a demanding one and we certainly will pursue family planning as of now, I should say. The child neglect situation, the abuse of children and so on, I think is equally proportionate if not higher than any other communities. I am afraid I do not have statistics available on this point. An example of the difficulties in the Territories is illustrated by the fact that the case worker for the Dawson Rail-Pelly Crossing area takes three weeks to complete her visits - three weeks of travelling on mountainous roads and in very hazardous conditions. How to deliver a program such as

this, such as we are planning now, would be one of the major problems. But this is something that we can certainly work out and we probably will be in touch with you, Mr. Chairman, and with Mr. Strehler.

Thank you.

Chairman -

Very good, thank you Mr. Van Der Veen and Miss Nolde.

Alright, let's pass on to Saskatchewan.

Dr. Grocott -

I'll speak first. I handed in a summary so I shall summarize the summary. We do have a family planning program but of a rather diminutive sort. When we first attempted to do this two or three years ago, and as late as 69, we were refused permission at the Cabinet level to even distribute literature. Early in 1970 the Health Minister and Welfare Minister, working closely together, slipped by our Treasury Board Minute giving us permission to print a pamphlet and pay for it. The public health nurses have been encouraged to use this at post-natal visits, pre-natal classes and on any occasion when they saw an obvious need but otherwise to give this information only on request. The same Minute also gave us permission to bear our share of the cost of contraceptive devices and pills and the like for many indigent families for whom we had previously not been able to do this and also in the northern health district where we have about twenty-five thousand people. Here we were able, on the basis that they had no pharmaceutical outlets at all, to distribute pills to the population, both Indian and non-Indian. This meant, in fact, that we were able to distribute them through our four outpost hospitals and through the public health nurses serving both Indian and non-Indian people.

There are no family planning clinics established. However, despite this fact, we have ordered all the regional medical health officers to go ahead and try and organize one although there are no funds available to pay for them. This is our most urgent need. We suppose that using public health facilities and health and welfare workers presently on staff that they ought to be able to run a clinic if they can dig out of their own budgets sufficient money to pay for special instruments and what not. But there would be no great rush to provide these funds.

In general we lack in the province any real political commitment to this sort of a program and there is no lay or other organization, except in Saskatoon, that has any interest in the matter. It is very difficult, at the public level, in the face of a falling birth rate - a tremendous diminishing in the actual numbers of births which have dropped by about a third in the last ten years - which has beguiled local opinion to the view that no active family planning program is, in fact, necessary. This is

particularly true among the medical profession who appear to think that under Medicare everyone who needs treatment gets it. They seem unable to appreciate that there are large groups of people, especially the welfare population and the young, who do not naturally go to their family practitioner for this sort of advice.

What we require, therefore, if I may roughly run through them, is that we have no funds to provide capital outlay to start our clinics and small sums would enable us to do this. We have no funds to provide the extra staff. We can use our present health and welfare workers but they would either have to be paid overtime for working in the evenings when these clinics most fruitfully are used or they would have to be allowed time off because of union arrangements and this would disrupt normal programs. If family planning is important, we should be able to have staff allocated to this function. We believe that among the education efforts, apart from the general public, there is the profession that need it because of their obstruction in the province to the establishment of clinics because they don't see the need for them. They, therefore, deny us the one source of funds that we have - that we could employ them on the contract rates under the Medical Care Commission, from which we have received permission, but we can't get any to take up the contract. It would help a little if the Welfare Department would see its way to bearing the full cost of the pills and devices instead of the half they now pay. As if there were only a national policy and some push at a high federal level, it would correct the deficiencies that our program has and influence public and political opinion in the province. By and large, our local legislators feel this is really too hot for them to handle and it needs a lot of higher pressure to get them to move.

Dr. Watkinson -

Thank you Dr. Grocott. I think it is very helpful to have such a frank and forthright statement. It puts the national government a bit on the spot but I think these things have to be recognized and stated. Now, Mr. Bethune.

Mr. Bethune -

Welfare tends to look at the problem this way. There are some three hundred thousand families in Saskatchewan. Fifty-one thousand of them have five or more children. Forty-two per cent of all the illegitimate births in Saskatchewan last year were the girls nineteen years of age or less. We take approximately two thousand and sixty-five children a year into care. This, to us, indicates there are approximately one thousand six hundred and fifty-one known families in Saskatchewan who last year were unwilling, unable, or unfit to have children but who produced a total of two thousand and forty-five children.

So, in view of the problem and in view of our commitment

to making family planning information available to those we could, we issued the following directive to our regional offices, and I quote, "On May 25th, 1970, approval was given for the Departments of Public Health and Welfare to make available to families, information and advice on how to plan the size of their family. As well, Medical Services Division was authorized to pay for welfare recipients under the Saskatchewan Assistance Plan, one hundred per cent of the price of oral contraceptives, intra-uterine devices and diaphragms when prescribed by a physician. Public Health has designed the attached pamphlet for distribution by its field staff and will make a supply of them available to us if we wish. We are to make no use of the mass media in this regard other than providing families with basic information and motivational counselling where deemed advisable and acceptable, rather refer them to their family physician for detailed information as to methods appropriate for them. This will, therefore, be your authorization to provide this information to those of our clients that you believe could benefit or appreciate it and to provide copies of the attached pamphlet to all families who request this information."

Since sending that directive, our regions have distributed approximately three thousand of the pamphlets. We have not tabulated, as yet, the number of devices that have been provided under S.A.P. We have held training sessions with our staff. We are presently in the process of preparing a slide presentation to be used in the training of staff as well as, if necessary, motivating our staff to provide the needed services. In one of our smaller northern communities we are presently undertaking an experimental project to determine some of the ways to serve the northern communities, the smaller isolated communities. It has basically taken the form of a blanket household mailing. The results are not yet known.

Our plans for the future are to work even more closely with Public Health so as to maximize our efforts. We hope to be able to steer clients to family planning clinics set up by Public Health in the future but if they are not available we can't do it. We shall also do the follow up. We hope to work with the Department of Education to encourage sex education in the schools as well as to involve, through training etc., the school guidance counsellors by enlisting their help in making information on birth control available and to provide the necessary counselling in the school systems. To this end we have begun by establishing, at the regional level in eleven regions, health education welfare committees composed of the regional welfare directors, the regional superintendent of schools and the regional director of medical health officers of public health. We hope that these three regional heads will each develop in their region the family planning program for their area.

I have a list of what I think is the need in Saskatchewan.

from a federal point of view. I thought we would save these until item eleven when we get to needs and priorities.

Dr. Watkinson -

Alright. Very good. Thank you very much. Let us now hear the picture from Manitoba and Mrs. Plesniarski.

Mrs. Plesniarski -

Thank you, Mr. Chairman. The Province of Manitoba is concerned with providing effective family planning programs and services that will reflect and meet the needs of the people of Manitoba. We believe that all human beings have inter-related and inter-dependent needs which call for an approach that will view people and their needs in totality. To this end the Manitoba Department of Health and Social Development is in the process of re-organizing and integrating all health and social services. We believe this integration to be an essential and key factor in the provision of effective services, family planning being one of them.

To date, our experience has been that unless a program carries an exclusively health social service label, federal funds are not available. Human beings are not, and cannot be treated as categorical items; nor can they be expected to seek services often while in a crisis state to a bureaucratic maze that is geared to professional disciplines, needs, and priorities. An integrated approach in health and social services is essential and we ask that the Federal Government recognize this fact. We also believe that any federal-provincial agreements concerning family planning should not be based on federal incentive grants which assist in initiating programs that lack federal money in the long run. Manitoba is not in a position to financially carry this burden alone on a short or long-term basis either.

To date our services include two family planning clinics that operate on a traditional basis within two local health units. One is situated in the St. Boniface Health Clinic opened July 69. This was to meet public demand. One operates in the Neepawa local health unit which opened in May 70. A third is scheduled to open sometime this year in the Brandon local health unit. It had been hoped that one of these clinics could be within a mobile unit. Funds were not available. This had to be cut from the budget. We are also in the process of drafting a cabinet position paper on family planning which will provide the guidelines for an integrated health and social service approach in this area. Again, I repeat, our province is not in a position to initiate and maintain these programs without federal funds.

Thank you.

Dr. Watkinson -

Thank you very much, Mrs. Plesniarski. I do think the federal members have noted your pertinent comments with respect to initiating programs without the follow-through. Can we move now to Dr. Khazen and Mr. Cornish in Ontario?

Dr. Khazen -

I will lead off and Mr. Cornish will tell you about welfare aspects of the program.

In 1966 there were only three clinics run by health units in Ontario. In 1967 the department had a task force to study the problems of family planning and this task force came up with seven recommendations. Nothing was done about these recommendations until the Minister, last October at the O.P.H.A. meeting, publicly suggested that every health unit should have a family planning clinic. In reviewing the activities in 1970, we noticed that in June 1970 OHSIP introduced what we call the "well-woman" examination coverage. It means the woman who is seeking advice or care from a private physician can have this service paid for by OHSIP and this covers her for two visits annually to the doctor. It also covers to the tune of twenty-five dollars an insertion of an intra-uterine device and vasectomies at the tune of fifty dollars. In August an international health service did a survey of all health units to find out what are the major obstacles for not providing family planning services and I will quote some of the major obstacles. We find at first that, at that time, there were only eight health units that do have family planning clinics. Some of them were co-sponsored with local hospitals such as the city of Toronto and the East York Health Unit.

Chairman -

Excuse me. How many health units altogether?

Dr. Khazen -

At that time there were forty-six, but now some of them have amalgamated and there are now forty-four, I believe, or forty-three. Some had clinics sponsored, as I said, co-sponsored with hospitals; others had them co-sponsored with private voluntary agencies such as in Ottawa, and now in Hamilton they are working together.

We had listed some of the major obstacles we feel would stop them from having family planning clinics and we noticed that twenty per cent of the health units listed the first major obstacle preventing them from having such services was absence of need for such services, which is amazing. Twenty per cent of

them listed the lack of interest of local practising physicians, meaning that they approached them but the practising physicians did not feel that they could or should be involved in family planning clinics. Seventeen per cent gave the reason as size and distribution of population or the line that since population was small and scattered they could really not have a central centre to have a family planning clinic. Seventeen per cent listed the reason as lack of funds and down the line - eight per cent, lack of physical facilities; five per cent, lack of trained personnel; five per cent, religious reasons; (in fact, one medical officer, and I quote, had said, "The recommendation of the task force concerning family planning clinics or services cannot be applied in the health unit because it runs against the teaching of the Roman Catholic Church "); three per cent, lack of support by the local board of health; and three per cent, low priority. We also asked in the questionnaire that if this major obstacle was overcome, what would be the other obstacles and we listed also the same obstacles. However, we won't go into the details.

To answer your question about priorities - we had everything in comparison with other international health services. Where would you place family planning service on the priority scale? Seventeen per cent placed it on a high priority, forty-five per cent on the same priority and twenty-five per cent did not answer this question.

As of this date there are nine health units that do have these clinics. Explaining these services - nine health units or departments have established family planning clinics. Four additional units are anticipating this service in the next year. They have, in fact, presented a request for financial assistance.

Speaking of financial assistance, there are two obstacles at the level of the local health unit. First is the medical officer who has to be interested and who has to start this. The second obstacle would be the Board of Health. I will quote an example - in one health unit, the medical officer was interested. On the local board of health, there was an obstetrician who was against it and he turned the tide and they refused to allocate the money. The provincial government will provide seventy-five per cent of the money for such a service and twenty-five per cent of money has to be provided locally.

In the field of counselling - the counselling is done, of course, by public health nurses where clinics exist or, where there are no clinics, which is most of the time, by the private physician. Other sources of course, (by a private physician and private hospitals, if you want to call them private hospitals, but I mean the services offered by hospitals only - there is a clinic, I believe, in Kingston and seven hospitals in metro Toronto-) are offering this service either directly or through the G.O.N., G.O.I.N. clinics.

In the field of education - the international health service started an extensive in-service training of public health nurses last June. We offer them the one-day institute either by itself or incorporated in a week workshop on pre-natal education for the nurses. This one-day institute focused on several main areas. First, the personal attitude of the nurse herself toward this service; secondly, the ability to collect data to help the doctor in the choice of the method because we feel that it is not up to the doctor to really decide on what method to be used by the family without knowing the background on the family and the maturity of the couple - their sexual adjustment and so forth. We try to explain every technique or method from the point of view of the emotional problems involved with the use of the methods rather than the physical side effects. Finally, we explain the role of the nurse in the community - how she can promote family planning services. We had twelve of these institutes since last June.

In the schools the public health nurses are finding it difficult to really work the way they want. First they are faced with the problem with the parents, specifically on personal counselling - a girl comes to them on Friday asking for something for the weekend and they are caught in between - should they help her or not help her? They are faced, also, with conflict with the principal because they do not want to introduce the subject in the school. But I must say that these nurses are doing a marvelous job. They are bringing the subject indirectly by turning the questions around and letting the students ask them for the service rather than just volunteering the service.

From the point of view of material, the Department of Health has not printed or produced any material. All the material that is being used is produced by the drug companies. Some health units are reluctant to use them because they feel that they are biased in some points.

We have only one film that was on the list yesterday presented by Mr. Palko but it is rarely used. There is a problem with the health education material because, as you know, they are abused and are not used by the right people, or the target people, we would like to reach.

As to future plans - we would like to promote the existing facilities because we notice that in some units the clinics are used where clientele is fifty or sixty per cent of unmarried girls going to university. We would like to try to reach large families - the risk families. We would like to provide or prepare some guidelines for the medical officer who is interested in starting family planning clinics - how to set up a clinic, in what conjunction should it be called a family clinic rather than a family planning clinic, finances, budgeting, etc.

We get requests from health units looking to the future and they need this to help convince the local board of health. We would like to expand the in-service training for public health nurses.

As I said, we are a bit reluctant, at the moment, to produce audio-visual material but maybe with the help of the federal government we can reach certain points of agreement.

I think that's about it for the health point of view.

Dr. Watkinson -

Very good, Dr. Khazen. Thank you very much. And will Mr. Cornish now speak on welfare for Ontario?

Mr. Cornish -

Thank you, Mr. Chairman. I begin by saying that the Department of Social and Family Services does not have, to my knowledge, an active stance or program in the field of family planning. We do, as you know, have a new Minister and we do not know exactly what the future holds there but I think at the same time, to be fair to our Department, I would say that we are doing a great deal in a subsidiary way to support present activities in family planning in the province. I list these specifically, as firstly, providing drug cards - which are a form of financial assistance to general welfare assistance recipients and in some cases to Provincial Family Benefits recipients - when these are requested through the municipal welfare department. These may be used to cover the costs of family planning drugs and appliances at the discretion of the municipal department. That has some implications because I must be honest and say that all of our municipal welfare departments are not picking up on this and it is, as in the General Welfare Assistance Act, at their discretion as a special assistance provision.

Speaker -

If they do pick it up what, if anything, does the municipality have to put out in terms of contribution?

Mr. Cornish -

The municipality, I believe, under special assistance, provides fifty per cent and the federal government provides the other fifty per cent.

Secondly, there is assistance in the form of transportation to family clinics but again these are provided at the discretion of local municipal welfare departments on the same basis as the previous one.

We have in our Department of Social and Family Services a newly constituted Family Counselling Services Branch. Many of these family counsellors are beginning and, as professionally trained workers, obviously are referring clients to existing family planning services when this help is felt to be appropriate or desirable. Some of our field assistants staff are doing the same. In that light, I might comment on, as other people have done, as to what kind of policy regarding dissemination of information exists. I think - as related by one of the other persons here - a recent reply to an inquiry as to whether our workers could carry cards of a local family planning association and distribute them as a matter of routine - I believe the answer was to the effect that they could carry these cards but that this would not be done except on the basis of the client requesting information so that indicates, to some extent, I think, the stance that has to date been taken.

A fourth point regarding present activities within the city of metropolitan Toronto - there are a couple of teaching homemaker situations which are providing, as a part of an overall program of family life education, some family planning education. This is actually in the Regent Park Housing Development.

Now let me comment on what we see we might be doing, and this is really speaking from the point of view of my own branch as to what we think we could do, at least - firstly, beginning to expand the role of the department in terms of education in this area in low income areas and not restricting our activities as had been done up to the present to welfare recipients, having a broader educational role there; secondly, providing information on family planning services as a matter of routine which, as I said before, we are apparently not doing (we are in the process of developing a handbook of services and also a handbook of welfare rights - I would suggest that information could be provided within that context in the same way all other information is provided); thirdly, encouraging social service agencies, both private and public, to provide information on family planning. We would put particular stress on community based organizations, neighbourhood centres and so on. As I mentioned earlier in our discussions in this conference, I think we would feel that training of local people to disseminate information on family planning is one of the most significant trends that should be followed up and again I suggest the aspect of using male workers to gain support of local men because this can be a bottleneck. Finally, and I'm not sure what I meant when I put it down, but providing more financial assistance for staff, for educational literature, drugs, services, etc. But where that financial assistance is going to come from, I think, is open to question as it is to some of the other provinces.

Thank you Mr. Chairman.

Chairman -

Thank you very much Mr. Cornish and Dr. Khazen. I

think we just have time for one more presentation and I would like to turn to Mlle Dutil. I believe you will speak "en français?"

Mlle Dutil -

Oui. Le Ministère des Affaires sociales du Québec s'interesse depuis plusieurs années aux problèmes de la planification familiale. Il n'a pas encore de politique officielle à ce sujet, mais il accorde des subventions pour encorager tous les efforts qui sont faits par des organismes privés et semi-privés, en vue de promouvoir des services dans ce domaine. On vous a parlé hier de ce qui se fait au Centre de planning familial du Québec, dirigé par le Dr. Mongeau. En 1970-71, le Centre a reçu, du Ministère, une subvention de $753,000. Mais le Ministère subventionne aussi des organismes qui préconisent d'autres méthodses de contraception, telle la méthode sympto-thermique de régulation des naissances. Ces organismes dits confessionnels ne désapprouvent cependant pas les autres méthodes et peuvent donner des informations sur toutes les méthodes. De plus, les deux organismes auxquels je me réfère font du counselling matrimonial auprès des couples. Qu'il me soit permis de les nommer : il s'agit de Séréna (Service de régulation des naissances) et du Centre de consultation conjugale de Québec. Les équipes Séréna travaillent dans toutes les régions du Québec et aussi, je crois, à l'extérieur de la province. Elles sont composées de couples-moniteurs bénévoles qui oeuvrent auprès d'autres couples. Chaque année, le Ministère octroie un certain montant à Séréna; l'an dernier, l'organisme a reçu une subvention de $15,000. Quant au Centre de consultation conjugale de Québec, il défend sensiblement les mêmes idées que Séréna; mais les couples bénévoles travaillent uniquement au niveau de la ville de Québec. L'an dernier, cet organisme a reçu du Ministère une subvention de $27,000. Le Ministère favorise également la mise sur pied de services de planification familiale dans les agences de service social, sans qu'on doive nécessairement créer des centres à cet effet. On suggère donc aux agences de demander la collaboration des hôpitaux pour toutes les questions médicales et faire elles-mêmes le travail social et la consultation psychologique auprès des couples. Dans cette même ligne de pensée, l'agence de Nicolet doit ouvrir d'ici un mois un service de planification familiale subventionnée par notre Ministère. Chicoutimi, Sherbrooke et Hull semblent aussi intéressés à la création de tels services. La réponse du Ministère à ces demandes dépendra du budget disponible, sans qu'on en fasse un "problème politique". L'approche du Ministère, en ce domaine, est nettement positive. Depuis quatre ans, le Centre de planning familial du Québec s'est tout particulièrement attaqué aux travailleurs sociaux qui oeuvrent dans les agences de service social. Par conséquent, plusieurs personnes réparties à travers la province peuvent maintenant répondre aux besoins de la population, même si les agences de service social ne possèdent pas de services structurés. J'ai omis un détail important en ce qui concerne le Centre de planning familial de Montréal. Depuis quatre ans, soit depuis l'existence du Centre, le Ministère s'est

tenu au courant de son développement et de ses activités en déléguant d'abord un représentant sur le comité consultatif, puis en représentant sur le conseil d'administration lorsque l'organisme fut incorporé. Ainsi, nous étions renseignés sur tout ce qui se faisait un peu partout à travers la province. Ne représentant que le secteur "bien-être" du Ministère, je suis un peu moins au fait de l'action entreprise au chapitre de la santé. Je sais cependant qu'il existe, à Montréal, des services de planification familiale dans au moins quatre hôpitaux francophones et trois anglophones. De plus, je crois savoir que notre Ministère subventionne un centre d'hygiène maternelle qui s'occupe également de planification familiale dans le centre-ville de Montréal. En terminant, je ne ferai un plaisir de répondre aux questions qui relèvent de ma compétence.

Président-

Merci beaucoup.

Mlle Dutil -

Permettez que je souligne un dernier fait: le Ministère a l'intention de mettre sur pied très bientôt un programme de projets expérimentaux. Des centres locaux de santé regrouperont tous les services offerts à la population, tant sociaux que médicaux, et les agences de service social seront aussi intégrées à ces centres. Nous voudrions cependant que chaque centre local comprenne un service de planification familiale.

Dr. Watkinson -

Encore une fois, merci beaucoup, Mlle Dutil. Well now, it would be nice if we had a few minutes to perhaps ask questions or even comment on the presentations which have been made. However, I think I will allow you a few minutes to collect your appetites before the 12:30 luncheon. We've made very good progress!

Chairman -

On the strength of a good luncheon we've come up with a proposal to make to you now to complete our session. First of all I would like to see us complete the review of the provincial activities, and in a moment we'll be turning to New Brunswick. On reflection, Dr. Splane and his colleagues, and Bob Lennox and myself, feel that we'll get the most out of the remaining period available to us by listening to you. The usual custom would be for the Chairman or someone else to summarize the needs and priorities. We think, however, that it would be far more useful if you were to tell us in summary form, the needs and priorities as you see them. The only way we can respond to them is by first knowing what they are. Perhaps you would be prepared to say to us what you feel the Federal Government program should be doing and we'll think of it in terms of supporting your program. Let us now turn to New Brunswick. Dr. Allanach?

Dr. Allanach -

Thank you Mr. Chairman. The program of family planning in New Brunswick has to date been limited in scope for possibly two major reasons, namely, one, the attitude of the practising physicians, both GPs and OBS and GYN specialists, and secondly, religious or ethnic beliefs and practices. With respect to the attitudes of the practising physicians, family physicians contend they are prescribing or practising family planning in their private practices. The prescribing of the pill, fitting of the diaphragm, IUD etc. is deemed by them adequate. Some physicians, however, have established out-patient hospital clinics such as the family planning clinic in St. John and the well-woman clinic which primarily was a cancer diagnostic service but is being extended in Moncton. This is a decided step in the right direction.

The matter of religious or ethnic beliefs and practices is a rather touchy subject. It should be noted, however, that in one city a family planning group composed of married couples, two doctors and two members of the Roman Catholic clergy have affiliated with the Montreal Family Planning Organization - Serena - and are giving talks and graphic demonstrations at public meetings and private interviews to couples on request. In yet another centre groups from some Protestant Churches are showing support to the Planned Parenthood Program while at the same time some younger members of the Roman Catholic clergy are generally expressing support to family planning and birth control programs. In fact, one reverend father has a radio program in which he openly advocates planned parenthood.

Recently the establishment of information centres regarding planned parenthood in St. John and Fredericton have demonstrated the public concern in the matter of family planning.

With respect to involvement by the Provincial Health Department in the program of family planning, the Public Health and Victorian Order of Nurses have provided a very limited service to those seeking such information. Such verbal information has never been volunteered but given only on request. The program is to be advanced particularly in the field of information distribution by the Health Department. Discussions in this regard are scheduled for mid-April.

I should like to say that as probably most of you know, there has been a divorce of Health and Welfare since the change in government and they are now under different administrations, although certainly the liaison between health and welfare will continue. We have a population of which about twenty to twenty-five per cent are receiving welfare benefits, taxes are probably as high as anywhere in Canada and we are very restricted in our opportunities to advance certain programs. What priority family planning has, I can't say, but the fact members from both welfare and health are here today indicates that the government is deeply concerned with the problem. Thank you.

Chairman -

Thank you Dr. Allanach. Mr. Gaudet?

Mr. Gaudet -

I don't think there is anything in particular that I would wish to add besides the fact that welfare is, like Dr. Allanach mentioned, just providing a referral service. Our staff are not particularly trained for this and have very little knowledge of family planning in general, I would say with a few exceptions. Our other contribution is that for prescribed drugs for welfare recipients the province comes in with the small note that the client has to pay what is called in New Brunswick a "Participation Fee" of $2.00 on every prescribed drug. In other provinces it is called a "Deterrent Fee". So I think that's all we are particularly doing in Welfare besides the fact I know our Minister is totally interested in this particular area of service. Like Dr. Allanach mentioned, I don't think there is any definite policy on it as yet.

Dr. Allanach -

May I add that we recognize that one of our major problems is the training not only of medical but also of para-medical people in this field. I foresee in the near future institutes of one form or another. The medical profession is fortunate in that Dalhousie University has, as you probably know, a continuing education program and members of Dalhousie's faculty and other qualified people do go through our province and meet with the members of the profession in hospitals and certain conferences and present various aspects of medical and surgical endeavours, and I'm certain that one of these days we'll have presentations on family planning. Thank you.

Chairman -

Thank you Dr. Allanach and Mr. Gaudet. We could move then to Nova Scotia.

Dr. Colford -

Mr. Chairman, my colleague has had to leave but he left a few notes and asked me to present them. I'll try to do so quickly after my presentation.

Since 1964, a family planning clinic has been in operation at the Grace Maternity Hospital in Halifax in association with pre and post natal clinics which have been held there for many years. These clinics have been supported by government grants, and pills and other supplies have been provided by pharmaceutical companies free of charge. Attendance at this clinic has increased over the years and at the present time they are scarcely able to cope with the numbers even though another clinic has been opened in nearby

North Preston. Supplies of pills, IUD etc. are running out and it's becoming more and more difficult to obtain them. The second clinic which I spoke about at North Preston - this is a black population and a very depressed area - was started about three years ago and we call it a family clinic. However, the Medical Director informed me just the other day that between sixty and seventy per cent of the work done there is concerned with family planning. It is staffed by a physician, public health nurses, residents and interns from the Halifax Children's Hospital and an general practitioner. Supplies are mostly obtained from the Halifax County Welfare Department. They too did obtain supplies from pharmaceutical companies until just recently and now the director says that these have been cut off. We have about 150 qualified public health nurses working in the province and they spend more than fifty per cent of their time in the homes. They visit close to 100 per cent of the newborn infants. For many years they have been giving advice legally or illegally on family planning but since the Criminal Code was amended they have established the policy making this part of their general regular activities. It has not been an easy course with this new policy. We have had many objections from different sources and you may be surprised to hear that even two of the health unit directors, of which we have eight, wrote letters to the Deputy Minister, letters containing more pages than words than what the policy itself contained, begging him not to implement this policy. Pre-natal classes have increased in numbers during the past year since we've had this policy and the demand for family planning information has been such that our nurses are now running an extra session in their series devoted entirely to family planning.

Last year at our Public Health staff meeting the whole day was devoted to family planning. We brought in resource people from the medical school and Ortho-pharmaceutical Company provided lectures and demonstrations. Since that time the staff meetings in our various health units have devoted at least a half day to inservice training in family planning.

Late in 1970 the Family Planning Association of Nova Scotia was formed. This is a voluntary organization which has its headquarters and counselling rooms in Halifax. Since the Family Planning Association opened its offices a few weeks ago it has had over ninety persons come in for assistance and we think that this indicates that there is a need for this kind of service. We think that need will be utilized more and more by the citizens as it becomes better known. Although most of the clients have been from the Halifax-Dartmouth area we have been receiving numerous requests for services by individuals throughout the province. Also interested citizens in several communities and agencies as far away as Kentville and Yarmouth have asked us to assist and join them in setting up family planning services in their communities.

The birth rate in Nova Scotia is rising in the last year. The preliminary figure for 1970 is over 14,000 compared with something over 13,000 in the previous year. The number of

illegitimate births in Nova Scotia has doubled in the last ten years and continues to increase yearly. Last year the number of illegitimate births was twelve per cent of the total births, is higher than it ever was. The number of abortions taking place in Halifax and in other hospitals in the province is increasing and it's becoming more and more a problem in talking to the medical people there, who are very worried and concerned about it. It's becoming demoralizing to the people who have to carry out these abortions. I am told this year that they are getting more and more repeaters.

The Family Planning Association is prepared to establish programs in Nova Scotia which will enable every family to decide when and if they have another child. Our proposals include (1) specially trained research workers to visit low income families in their homes and assist them in all aspects of family planning, (2) professional cooperation including training programs referrals to sharing of literature etc. with those personnel who are in contact with low income families or any person who may be in need of family planning. We especially plan to work closely with public health nurses, community doctors, welfare case workers. (3) community education programs utilizing mass media, panel discussions, speeches, literature etc. (4) establishment of family planning centres for information and referral and examination of the need for medical clinics throughout Nova Scotia and (5) the establishment of such clinics with the cooperation of community doctors, agencies and public health nurses etc.

Now with the exception of the two clinics that I mentioned, all the other family planning activities in Nova Scotia are concerned with counselling. Clinic services, drugs, informational materials and other supplies are urgently required and as yet we do not have the means of obtaining these in sufficient quantities. I should say, the matter of pills, IUDs and this kind of thing. I'm not too clear on just what goes on between the Department of Health and the Department of Welfare in this respect because in talking to officials in the Department of Welfare following the Canada Assistance Act and the Canada Assistance Plan, we were assured that there would be no difficulty in obtaining these but now on checking with them just recently I am assured that they have no part in providing any of these things in either one of these clinics or by any other means although in talking with Mr. Burns on our way down here to this meeting he says that they have been supplying some so it's a bit confusing to say the least.

We feel the need of family planning clinics where interested physicians will attend. Over and over again our public health nurses are sending patients to their doctors. The next time they see the patients they are pregnant. So many doctors just do not provide the kind of medical care that is required. In Nova Scotia our medical care plan does not yet provide for family planning services, as was pointed out already this morning.

We need informational materials in large quantities, even a simple pamphlet to start with would be a great help - something that we could pass out to the public. We need materials for the people who are teaching and the nurses. We have a need for continuous inservice training, particularly for nurses. There is a great deal of talk about research - we are not stressing this too much. We acknowledge that there is a need for research. However, at the moment, our most pressing need is for more action in the way of clinics and materials to provide the purpose of family planning.

I should add that we are working along other lines. I have been involved with the Department of Education in an interdepartmental committee meeting dealing with education and health and in the last five years this committee has worked on a guide for health teaching and this is now in the hands of all the teachers in all the schools in Nova Scotia. It contains quite a good section on sex education directed to the lower age groups. I also serve on a committee called the Family Life Education Committee in the Department of Education and this committee has been very active over the last twenty months in family life education. We have succeeded in getting an institute put on the program at St. Francis Xavier University for this summer. There is space for eighty school teachers who will be at this institute and it will be able to give them university credits. Mount St. Vincent University is also giving a similar course in family life education which includes family planning.

Mr. Burns in the Welfare side has left a very short paper. If you wish, Mr. Chairman, I will give that also. He says, my comments are brief because our department's efforts in family planning up to this time warrant only a brief statement. Before the change in the Criminal Code neither the Province of Nova Scotia nor any of its departments had a policy on family planning. A few private clinics offered a counselling service and prescribed contraceptives to persons who needed and requested such services. At the same time over the past ten years several municipal welfare departments provided a counselling and referral service to clients in need of family planning. Costs of contraception pills and devices for welfare clients were borne by the municipal welfare departments in addition to the welfare provided. Throughout the province these funds have been estimated at no more than $2,000 a year.

Following a change in the Criminal Code the Department of Public Welfare established its policy on family planning. This was sent to all public and private welfare agencies. The Department of Public Health also has its own policy, which I have already stated. In 1970 the Family Planning Agency of Nova Scotia was established (I dealt with that also). The Department intends to provide funds for this new association so that technical expertise and counselling services can be quickly available to our people

in Nova Scotia. If properly funded, the family planning clinic will serve as a voluntary resource to many of our welfare agencies. The major problem we face in Nova Scotia at the moment is the training of our department of public welfare staff, municipal welfare department staff and CIS staff in counselling clients in family planning where there is a need and where the clients request services.

I should add regarding this voluntary agency - the Family Planning Association of Nova Scotia - they have no funds. They are all voluntary people and have no funds whatever.

I was talking to the President the other day and he said they don't even have money to mail letters. And they want an executive director. They have approached the Provincial Government for money. They're putting on a drive for funds at the very worst time. Although I did make a small contribution myself, I told her it was the very worst time because we were all grappling with our Income Tax returns. They haven't been very successful to date in obtaining funds.

Thank you, Mr. Chairman.

Chairman -

Thank you, Dr. Colford. This is very helpful.

Dr. Colford -

Mr. Chairman, may I add something on the welfare side. One of the first ventures of the family planning association in Halifax was an exhibit at the Maritime Winter Fair and the Department of Welfare were kind enough to subsidize it. I think it's very interesting that they had 2600 people fill out questionnaires at that exhibit expressing interest in family planning.

Chairman -

Thank you again Dr. Colford. Can we move on now to P.E.I. and to Mr. MacDonald and Miss Rowland.

Miss Rowland -

Until very recently open discussion about family planning was definitely suppressed, although as in all the other provinces the public health nurse did advise people where they saw the need to consult with their family doctors. Now there is open interest shown and the medical society has discussed the need for a family planning program. Contraceptive pills are being prescribed for low income people and in one hospital a considerable number of sterilizations are done with a medical reason given. The Deputy Minister of Health is keenly interested since the illegitimate

birth rate rose so markedly even though the birth rate itself was lower, the general birth rate and infinite death rate is lower. I would see the main need is training for personnel as the other provinces have said.

Chairman -

Thank you Miss Rowland. We'll turn now to Mr. MacDonald for the other part of the picture.

Mr. MacDonald -

Thank you, Mr. Chairman. The Department of Welfare does not have a formal or structured program nor does it have a stated policy with respect to family planning. As in many places informal counselling is done by Social Workers but this is not by way of a program and the practitioner is doing considerable family planning with his patients - again on an informal basis. Now, within the past year I would say, and especially within the past six months, quite a marked increase in interest has been shown within the Department itself with respect to this need. We are presently undergoing departmental reorganization and within that reorganization certainly will be included family planning, although I must say that it's not high on the priority. Other things are going to be given first priority. The Minister has indicated quite an interest in this and he is most anxious that we attend this conference and report back. In Prince Edward Island we have a Human Resources Committee made up, for the most part, of deputy ministers of the several departments concerned primarily with the human resources aspect of things and we will be reporting to that committee. Also we have a Health and Welfare Planning Committee and we shall certainly be reporting to that committee. I might add that the Health and Welfare Planning Committee has had family planning on its agenda for some considerable time and although we haven't gotten to that item yet, it's getting fairly close to the top of the priority list at this time. So I can report that within our plans we have family planning as an item for discussion and study and I would say that before we could indicate or relate to the federal people what our priorities are that we should first on the provincial level convene an intradisciplinary study group, study the matter locally and then I think we'll be better able to indicate to you federal people just what we think our provincial needs are.

Thank you.

Chairman -

Thank you Mr. MacDonald. I hope that the visit of yourself and Miss Rowland to Ottawa and your participation in this present meeting will raise the priorities a few notches. Well then, we've reached the Atlantic Ocean and we can complete the picture with Newfoundland. Dr. Severs and Mr. Tiller. Who's leading off?

Mr. Tiller -

Mr. Chairman, Dr. Severs and I have decided to reverse the procedure followed here today and possibly for the first time in the history of Newfoundland, Welfare has been given priority over Health.

I'll be very brief, sir, because I have no other choice; really there is very little to comment on in our province. Our Provincial Department of Welfare, now known as the Department of Social Services and Rehabilitation, has no organized family planning program. Our field staff have not as yet received any training in this area and they have not been provided with educational materials or literature for distribution through our regional offices. It would not be entirely true, however, to say that we are not involved at all in the area of family planning because limited counselling is provided by our Child Welfare, to a lesser degree by our Social Assistance and also by our institutional workers to wards of the department, unmarried mothers and adults in receipt of financial assistance. Information provided by these people is given informally and on an individual basis as there is no formal organized program as such in the province. Our Department does help clients financially through the provision of health care cards, whereby the costs of prescribed drugs and other medications are provided free of cost to our welfare recipients.

I don't want to steal any of Dr. Severs thunder but I perhaps should mention one or two things that might overlap with his report. The Health Education Division of the Department of Health does have some leaflets and booklets and other literature on family planning available on request, and throughout the province we have made use of some of this in the Department of Social Services, but being a representative from the St. John's office only I can't really speak on what's been happening throughout the province. I wish I had known a little in advance that this conference was going to take place and I could have come better prepared. However, no doubt some use is made of this literature that is supplied by the Health Education Division and as I have already said I don't think our Department has been involved to any great extent in its utilization. I might also say here that to the best of my knowledge no private agencies (I'm thinking specifically of welfare agencies) are involved in a family planning program in Newfoundland at the present time. It is my understanding, going back to the Health Education Division for a moment, that several films and booklets are being evaluated at the present time and these will probably be available for province-wide distribution in the near future. However, we are now just beginning to build up a supply of literature and other material for the use of interested people or organizations in their efforts to promote family planning. Information and counselling is provided mainly by local doctors and public health nurses and with the exception of one family-life clinic in the city of St. John's, which Dr. Severs probably knows more about that I do, there are no organized family planning clinics in our province.

In the Department of Social Services, at the moment, I see our function as being that primarily of a referring agency. However, the field staff of our Department could make a valuable contribution through their direct involvement with clients if family planning information materials and special training opportunities were made available to them. This perhaps is or should be our primary objective from this point on. Specific training could be provided through special training sessions or seminars or possibly some family planning training could be included as part of our regular departmental in-service training course. I don't know what the possibilities are for this to happen.

In concluding this very brief report, may I say that my prime objective upon my return to Newfoundland will be to pass on to officials of the Department that I represent the message of this conference with a view to helping them realize the necessity and importance of a family planning program to make information available and also to make services available to all of our people who desire them. Concerning the specific things you asked us to mention or comment on, sir, as I've already pointed out perhaps our primary need would be for training at the provincial departmental level. By that I mean the senior officials of our Department or some representative who could perhaps be trained as a field worker or a consultant to work with our field workers throughout the province. To my knowledge no official stand has been made as far as the provincial government is concerned on family planning and it seems that our major efforts in the very near future would be to stimulate an interest in officials of our own Department and government officials and also of course to concentrate on training of personnel for the dissemination of family planning literature and other information.

Chairman -

Thank you, Mr. Tiller. We'll give Dr. Severs the honour of winding up the presentations of the provinces.

Dr. Severs -

I think Mr. Tiller has probably covered most of the ground but perhaps I should just say a few words. The Department of Health itself has no official policy with regard to family planning and there are no voluntary organizations so far as I know active in the province in this field. Shortly before Christmas a special clinic was opened up at the Grace General Hospital in St. John's. This is called a Family Life Clinic and I think that the primary intent of this clinic is really to provide a teaching facility for medical students at the new Medical School of Memorial University. The Health Education Divison, as has been pointed out, does supply literature. This by and large is made available on request. The Department of Health makes drugs and devices available to cottage hospitals where there are no pharmacies. During the last two years we have devoted a certain amount of time

to inservice training of public health nurses. We have had several sessions on family planning with these ladies. So there is some activity, although there is no planned program. Looking to the future I think that probably this conference will give some impetus to perhaps a planned program in the province.

Chairman -

Thank you very much Dr. Severs. You have raised a point that occurred to me earlier. May I ask Mr. Strehler is it the intention of the Canadian Federation to develop branches in P.E.I. and Newfoundland, the two remaining provinces?

Mr. Strehler -

We're actively seeking the volunteer base upon which we can build the voluntary organization.

Chairman -

And am I correct in thinking that if the Canadian Federation were active that this could be helpful perhaps to the official efforts?

Mr. Strehler -

Yes.

Chairman -

In P.E.I. too?

Mr. Strehler -

I would think so, Mr. Chairman. And the fact that there are representatives here from both health and welfare reveal at least a ray of hope that our provinces show an interest.

Chairman -

Good. Well first of all, let me thank you all for your very helpful presentations. I think these are extremely useful. The interesting part is to learn about the different approaches that you are using to meet local conditions. This is so characteristic of Canada, being such a diverse country. It is always interesting to go from coast to coast or from the south to north and to realize that there are a variety of ways of achieving the same objectives. Perhaps you will agree that there's much to be learned from each other in these presentations. They are time-consuming but they do provide useful information. In any event, we will be very pleased to have this record.

We're keeping within our time schedule and within the next hour we would like to hear further from the representatives of the provinces.

Mr. Bethune -

I'd like to ask a question before we move into that, of Quebec. You seem to be the one among the bulk of us to have the strongest, most highly developed private sector. Now I have heard all the credits that Dr. Mongeau has been getting. Do you think this has hindered you in any way in developing a publicly provided family planning program?

For instance, if Saskatchewan had such a strong private sector, it would be a beautiful way for our Government to cop out.

Speaker -

Il a de la difficulté d'avoir la protection si vous voulez ou le support du gouvernement pour les services de planification.

Mr. Bethune -

You seem to have the most highly developed sector. Has this hindered, do you think, your development in Quebec, of a publicly sanctioned family planning program?

Chairman -

The government has the same opinion as the centre of Serge Mongeau. We agree with what he is doing in Quebec and we give him some grants so there is no contradiction. Is that your question?

Speaker -

Je voudrais savoir si la présence d'un groupe voluntaire.

Speaker -

de bénévoles

Speaker -

oui d'un groupe bénévole empêchera le gouvernement ou plutôt

Speaker -

d'un groupe qui ne serait pas d'accord avec ca

Speaker -

non je crois qu'il a la confiance de dire comme quoi ce groupe prendra la volonté du gouvernement et le gouvernement ne sera pas content ou bien n'offrira pas les services s'il y a un groupe volontaire déjà fonctionnant dans ce domaine, est-ce-que vous croyez que celà pourrait exister.

Speaker - Dutil ou Arcand

Non. I think that some clinics will develop soon in the local health centres of the Province of Quebec. Le centre de Serge Mongeau is not the centre which gives direct services so we will develop some services.

Chairman -

Thank you very much.

All right, we've got approximately an hour left in which to conclude our meeting and, as I said earlier, we now want to sort of synthesize these discussions to crystalize the salient features and keep our eyes on the needs and priorities. In particular, we want you to say what you feel are the best ways in which we and the federal government can help you. I'm sure that Mr. Strehler, on behalf of the Canadian Federation, will also be glad to hear with respect to the application of his organization.

Now who's going to lead off? Mr. Gaudet?

Mr. Gaudet -

Yes, Mr. Chairman, I have one concern that I think is not only relevant to our province but to several areas of Canada. I'm particularly referring here to those less developed areas of the provinces, mostly the rural areas. It would seem that it's kind of a contradiction that services, family planning services are being developed into areas where people are more conscious of family size, where living and housing environments to some extent dictate family size. Now when we situate ourselves in some of the rural areas quite often the homes are larger, people are none the less poor, lack of jobs and whatever. Therefore, and I guess we've heard from the Yukon and the Northwestern Territories about the mortality rate and the various child neglect and other factors of this nature, I wonder if, in this particular area, the Federal Government should not take a more active and direct part in instituting services in the less developed areas of the country. It seems to me that we have numbers of small settlements - people are going to be there for a number of years - they're not going to move to the big cities like some of the central government people in Ottawa would wish to think quite often. I have a strong feeling that those people are going to be there for a long

long time, maybe mobility will apply to their children but not likely to a lot of the adult families. I just wonder here if the Federal Government could not take an example from the Emergency Measures Organization where, you know, special kits of all sorts, special training sessions of all kinds were highly encouraged (not to use some stronger words) on the provinces. I just wonder if the Health and Welfare Department should not consider something as tangible as providing those areas of the country with mobile family planning clinics equipped, maybe assisting in training the personnel. I think these are some of the tangible things that we should start considering if we want in fact to say that family planning is a right for all Canadians.

Chairman -

Thank you, Mr. Gaudet. I think your suggestion about looking at mobile family planning clinics is a good one, but I think we shall have to recognize that this is an area which the provinces may want to regard as their own. But that's not to say that we should not look at these ideas and work with the provinces.

Mr. Gaudet -

That was my intent. I wouldn't want the Federal Government to operate these.

Mr. Huesing -

Mr. Chairman, it seems to me from listening to the various provinces and recognizing our own situation that there seems to be two very great needs which I think have almost been unanimously expressed. The first one probably the more essential one is that of the lack of the necessary capability to train field personnel in the carrying out of family planning. I'm wondering whether or not it might be possible for the Federal Department of National Health and Welfare to get into manufacturing some type of course - whether it be a home study, correspondence, what-have-you, sponsored on the federal level which could be made available to field workers in any province in Canada. It seems to me this would have several advantages. I believe you probably have the facility for getting funds for this type of purpose. You also have, probably, a greater amount of resource personnel in the various fields of expertise to develop a fairly comprehensive educational package which the provinces individually could not afford. Certainly, in our case, there is absolutely no way we could afford to gather enough expertise to make any kind of a family planning educational program a viable thing. The second one is the matter of information material . Again I think the parameters are roughly the same. You have the facility for the expertise. You can draw on so many sources . Dr. Brown's statements during this conference certainly indicated that you have a vast storehouse if you like of knowledge - why not make use of it in a way that all provinces in Canada and the Territories can utilize this on a ready basis.

Chairman -

Thank you. Now, just let me be clear. The first point, I think, referred to putting together a unit of people with expertise in imparting information, training them - that is, to provide training. The second part related to providing a similar kind of expertise in the development of the educational materials which could be made available to assist the provinces and territories.

Mr. Huesing -

I don't think I've quite made that as clear as I wanted to. Keep in mind that it came at the spur of the moment. No, in the first instance, what I was thinking of was some form of package program for utilization by field workers in any province which would provide them with essential training in the family planning area, recognizing that this may well be on a correspondence basis or something akin to that.

The second one was the reason why I emphasized the fact that you do have a great amount of expertise that it would be logical from my point of view for the Federal Government to put this expertise together to develop an information program whether it be in the form of literature, in the form of films, in the form of TV specials or whatever the provinces could use on a package basis. The Federal Government would do the necessary work to prepare the package for utilization. Is that any clearer?

Chairman -

Yes. Some one mentioned the preparation of a syllabus that could be used to be followed in the area of training.

I wonder, were you referring also to work shops and seminars? Was this part of your suggestion?

Mr. Huesing -

I would say that would be a natural continuation of any educational program. I thought the idea of having a correspondence sort of thing, that you would probably reach more people in one grab than you could possibly do by university courses or continuing education courses or work shops or things of this nature because it would mean taking field personnel out of the field locations and placing them somewhere else which would place some sort of administrative burden (if you like) on the provincial authority.

Mr. Van Der Veen -

Mr. Chairman, may I make just a few comments. First, I think what has happened at this conference is a sort of cooperative federalism in miniature and I think it's a very gratifying experience. May I suggest that this type of thing continues. I think it's most

advantageous, particularly for those provinces where perhaps the governments in power are somewhat reticent to embark upon some of these programs. May I also make the suggestion, Mr. Chairman, that we continue our liaison in the form of correspondence, on a ongoing basis, with perhaps some interchange of the progress that this or that province or territory may be making. I think this material we would amass over a period of time would be invaluable in the further promotion of this program or any other subsequent program that we may wish to push. I think this has been a most valuable experience. Thank you.

Dr. Colford -

Mr. Chairman, I spoke of continuing education on a local level. But now I'm wondering if it would be feasible for the federal people to go as far as to set up something similar to what they did with the emergency measures - set up a school at Arnprior and invite people from all over Canada to come and take part. I wonder if such a thing could be done in family planning?

Mr. Chairman -

That might be a good idea.

Mr. Cornish -

Mr. Chairman, we from Ontario would think in terms of the training and resource materials aspect of our needs. I'm wondering if it might not even add more prestige to the area that we're discussing if the Federal Government were to develop perhaps a national institute on family planning which would be a training and resource materials type of approach to the problem.

Dr. Khazen -

It was mentioned many times that sometimes the family physician or the practising physician is at fault. I'm wondering if the Federal Government, through the Medical Association or Mr. Strehler's association, can bring some pressure or provide some inservice training for the physician to be up to date or at least make him know about services available. Also, concerning Ontario, as I said earlier, the members of the Board of Health are sometimes reluctant to approve such projects. Maybe you can approach them in a way for this service.

Secondly, we were talking about clinics and most of the clinics that we mentioned are either in a health unit or in a hospital setting. As you know, these clinics are not one hundred per cent successful because they do not reach the people that need this service. Is there any way to receive financial assistance to bring the service to the client through satellite clinics or neighbourhood clinics or community clinics or whatever? Maybe clinics is the wrong word - centres?

Chairman -

Thank you Dr. Khazen. I've forgotten whether our involvement with the Canadian Medical Association was mentioned. I might say that with regard to the use of the International Planned Parenthood Federation Medical Handbook, we have had assurances from the Canadian Medical Association that prior to general blanket distribution of the handbook to physicians in Canada, which would go out from the department in an appropriate way, it would be prefaced by an article in the C.M.A.J. addressed to all physicians, lending encouragement to the program and generally lending their support. This is, perhaps, along the line you speak of and I think you can be assured this will continue.

The question of support to the development of satellite clinics would likely be covered under one or other of the shared programs or grants-in-aid that were discussed yesterday. Perhaps you might give some thought as to whether they are eligible for support of one kind or another. If you are in doubt, please don't hesitate to write or visit us.

Dr. Grocott -

As far as a legitimate dissent is permissable in this meeting I'm surprised that so far everyone is worried a bit about training. I really can't see this when you see how widely contraceptive practices are in fact used and the people that we're dealing with - nurses, teachers and this that and the other - ought to know about this and in fact do know a great deal more than they let on. It's only their, perhaps, personal hang-ups that make it difficult for them to part with the knowledge they already have. They're not used to dealing in this field; but I don't really see the need for federal financial help being solely concerned with training. In fact, I would loathe to think that this was the only way in which they were to give money or even give it as the highest priority. Where we are concerned certainly in the province of Saskatchewan is the small infusion of cash and we could start clinics by the end of next week in the two largest cities - one through private agencies and one through the municipal people without any problem at all. We'd have a little more trouble with our own government people-we could do that, too, with an infusion of cash of the equipment variety as you did once when we wanted a test hearing and what-not - we got a great deal of money to provide this sort of stuff- and then we could immediately use it. If we had a similar thing for equipment to set up a clinic, we could immediately set them up I am sure, without any difficulty. The other problem is the additional staff, or payment required for such staff, to reach the rural people and this is where most of the money, I think, would go because they really must be reached; and yet the answer that we always get from medical officers is that it's perfectly all right to start these things in Saskatoon and Regina and North Battleford and places but we can't go trotting around the villages to every hamlet of five hundred when this is in fact what they do need to do, and this requires more people. That's where most of the money would go.

My simple message is that money talks and with a little bit of money we could solve our own problems very quickly.

Chairman -

This is very helpful. I wonder if it would be helpful to you in Saskatchewan, in so far as your own interest in the program is concerned, if you were to jot down some of these thoughts about how you could undertake a program, providing you had financial support. Dr. Lennox and I would be glad to hear from you and explore from our end what we can do to help.

Dr. Grocott -

We're more interested in the service element and we don't fit into the schemes that already exist, except in a very educational field. We thought we might dig into one of the research grants, for instance, to start a program of peer group education where especially the junior high, high school and university people made video-tapes in their own vernacular which would get across to their peers better than any one else. That might fit into the program. But we're more concerned with the service element and none of those programs really suit our purpose.

Mr. Bethune -

Can I try and get for welfare what Hugh just got for health?

I'm trying to second what Hugh said, that we're after money. But I'll try and word it nicer than that. For instance, I'd like to attack your program right back where you gave us your objectives. I don't think that you've given us here basically our objectives at all but their methods. I'd like to see Ottawa simply state that its objective in this whole area of family planning is to promote the publics' acceptance of responsibility to plan their families. Then any method is open to you and the provinces to try to achieve that objective and the number of methods are surely only limited by our imagination. Then it becomes a problem, and this is what we should be talking about here, what role, which method is most effectively done by the province, and what role, which method done by the Federal.

Now, that being said, we think for instance that you can help the province carry out its certain roles, and I am trying to list these. For instance, I'd like to see you change the Canada Assistance Plan rules to help us develop welfare services programming. I think that means you're going to have to redefine your concept of

preventative service or welfare service for instance so that a family planning program which is aimed at all the population and not just those in need or those likely to become in need - you know - get truly preventative. We have always argued that point with you. We figure once a problem shows up anything you offer from that point on is remedial and not preventative and we want to do preventative programming. We also, as I have described to you personally, like to see you change your eligibility rules. We would suggest a sliding rate of costing for a number of years if you want so that you can begin to lead in certain areas and also I think because then you can assume some of the risk of new service plans. Right now you will agree to cover fifty per cent of the cost of these services but the province is paying more than fifty per cent because it's assuming the risk in developing the design and so on. I think one role that the Federal Government can play is try to lead the public attitude. For instance, we believe that to be effective a family planning program must do more than simply provide information as to method which seems to be the approach here. We think it must attack public attitude and for instance, we think that to be effective, birth control must be a publicly accepted good. People must see and hear contraception information as easily as they do soap commercials or advertisements for panty girdles. We think this means you've got to use the mass media. We would like to see the private sector help to get involved in this area. If we're not allowed to use the mass media, there's no prohibition of the private sector. We'd like to see the drug companies themselves be turned on to this. I think one advertisement, for example, in the Regina Leader Post by Goodyear Rubber would save us a thousand words and dollars in the approach to public attitudes and the acceptance of family planning.

Ottawa could take some of this risk, this lead time risk. Sure we'd like more training money, but I'm not interested only in money aimed at training our welfare staff. We'd like conference money - to hold conferences of public and private people in the province. We'd like travel money to come to your national institutes and conferences like this because, let's face it, we have so little money in our family planning program that we are not going to devote any of it to come to any more conferences like this, although they're very good - we just don't have it. The price it would cost the province to send me down here would put out another five thousand pamphlets. They'll buy the pamphlets instead of sending me down here. Welfare grants - all right - this is the gist of my question to you, Quebec. Do we put welfare grant money to the private sector? I don't think I'm clear in this in my own mind but I would think I'd like to see federal money go to grants to private sectors. You said you'd do it to national organizations - what about local organizations? We have local groups in our province that could use some of that money. They have no national appeal. I still think you have a role, you could assist them. Well, we'd also like to see the welfare grants division changed to provide more grants for service programs and not just demonstration and research programs. We'd also like to see the Federal Government

strengthen its own services in the area of family planning to those people in our province that they have responsibility for and I'm thinking of the Indian. The highest birth rate in our province is on the Reserves. They're your responsibility. You're not really doing anything. We think you should. Maybe you can lead some of our people that way. I'd like to see you work to clarify all the federal rules that are hanging us up - the Criminal Code, one of them we mentioned earlier. We'd like to see the Federal Government try to take on some of the national groups that are hindering us and I'm thinking of the Catholic Church. I think we've got to get their whole area in this thing clarified. It might not be a problem in some of your provinces. It is in ours. Why nobody from education here? We've got to get education involved. We in Saskatchewan work very closely with education - almost to the point where maybe the only thing we can do to be effective is to write off this generation and start with the kids in school today. And yet there's nobody here talking for education or about education. I'd like to see the Federal Government become a clearing house for information on family planning for not only the provinces but North America so that you feed us information. We'd like to see you provide or pay for, better yet, although I'm impressed by the Northwest Territories' argument that you have the skills, I'd like to see you provide us with informational devices such as T.V. clips, slide presentations, pamphlet material. We'd like to see you play a bigger role, as I've already said, in organizing the private sector. Why not a family planning federation organization in Saskatchewan and give them a grant to come out and set an organization up in Saskatchewan or something of this nature. We think that C.A.P., by the way, should contribute to the cost of planning programs. This costs money, even in the collection of the data. The running of our computer costs a thousand dollars an hour. We think you should share in this even in making federal statistics available to us, Manpower statistics, Revenue statistics that can help us plan. We think you can help us more in this area than you have. We think your C.A.P. should share the costs of welfare services, no matter where they're provided and that might be the costs of welfare services provided in the schools by the guidance counsellors or public health nurses when they're talking family planning. Is this a health or a welfare service? I think certain public health nurse costs could be shared under C.A.P. as a welfare service.

Dr. Splane -

Well, I have listened with interest and appreciation and acceptance. I think I might establish that in some instances here what Blaine Bethune is asking for is available either just as he wants it or in a variant. There are some instances, certainly, where what he is suggesting is not in the provisions of our programs at this point, but as he would also know the C.A.P. is up for improvement and we'll be out in the Provinces they're talking about things the fourteen areas that were referred to in the White Paper together with additional ones that have been suggested since then including

the ones that he has just put forward. Some of them, of course, go beyond the C.A.P. and so I just want to say thank you to Blaine for this very impressive addition and stimulus to our thinking.

Mr. Strehler -

I have a small suggestion, a request that might sound trite but with my communications background it's none the less very important to me. Our own associations are producing books on family planning birth control information. It's obviously being done in the provinces. We are now faced with the Federal Government becoming involved in producing a great deal of information and I think that it's extremely important that some sort of symbol is agreed upon, drawn up now that will subsequently appear on everything concerning family planning, whether it be used in the voluntary sector, whether it be used at the provincial level, whether by health education, that people will get used to. This has been used extremely successfully such as with window stickers in drug stores in other parts of the world that people will accept this symbol being synonymous with,"this is where they can get family planning information"and I think that it's very important at this time now that we do bear that in mind.

Chairman -

Thank you very much. That is something that we can look into. Dr. Colford.

Dr. Colford -

Mr. Chairman, I don't know whether there is much left to be said after hearing Mr. Bethune. However, I would like to just emphasize again that I don't really think that training is the most important. I agree with Dr. Grocott there. I don't think that that's the highest priority, although, I did talk about it. The highest priority right now, as far as we're concerned, is to get the materials, get the pills and to get the IUDs. We counsel people. We send them to their doctors and the doctors prescribe for them but then they can't get the necessary wherewithal, they're not welfare people. If we could work out some way by which these things could be provided, I think this would be a big step ahead.

Mr. Cornish -

Mr. Chairman, with reference to this training, which I supported. I hope we don't get confused as to what we are talking about here, whether we're talking about technical expertise in the provision of birth control methods or whether we're talking about a way of presenting the whole business of family planning to the community to people in need of this service. I think that this is where the training thing comes in - where people develop-public

health nurses, social workers, etc. develop some kind of confidence in their ability to present this program as another service as opposed to training. I think this is where the biggest hang-up is, aside from the fact that we don't have the dollars and cents to provide the means.

Mr. Archibald -

The only comment I have to make, again related to training, is that I feel the Federal Government can provide guidance into what sorts of training can be provided at the local level. Something that we haven't touched upon in these two days is the scope of the training and I would hope that guide lines would be established to include that the people that would be delivering this service would have opportunities to work through their own feelings in regards to sexuality.

Before coming down here, I met with a group of doctors that are involved in various operations in Edmonton and this is the one point that they really emphasize, that many doctors feel inadequate in they can't deal with these questions properly because of their own attitudes towards it. They have very basic attitudes of sexuality and extending that into the entire field of family life education, I think it's part of it and that this training should be done in that context.

Dr. Watkinson -

Thank you. Mr. Archibald gave me and perhaps to others, a copy of a number of recommendations. Do you wish to make any addition to them, Mr. Archibald, at this point?

Mr. Archibald -

I'll leave that up to you. I'm just reluctant to take the time.

Dr. Watkinson -

A number of these, am I correct in thinking, you did mention in your presentation this morning?

Mr. Archibald -

Yes.

Dr. Watkinson -

Well then, we'll keep them for the record and thank you very much.

Miss Dutil -

I will speak in French? Je ne sais pas si ca déjà été

dit, je ne crois pas, je manque des bouts des fois, j'aimerais que chaque province soit tenue au courant de ce qui se passe, des développements des autres provinces ce dont on était pas tellement au courant à date et aussi je me demande si ca serait possible, si l'Association Canadienne pour la Planification Familiale si c'était possible de faire parvenir de la documentation aussi, est-ce-que vous avez un journal, une revue qui parait qui pourrait être envoyé au divers ministères partout au Canada?

Chairman -

A publication of the functions of the Family Planning Federation of Canada in French to be forwarded to ....

Are you thinking of the Canadian Federation or of the Federal Government or each of the other provinces or all of us maybe?

Mlle Dutil -

Lorsque je parle d'un envoi de revue je parle de l'Association de Monsieur le directeur je crois, c'est la Fédération ou l'Association? C'est la Fédération, alors s'il y a une revue j'aimerais qu'elle soit envoyée aux ministères (au pluriel) provinciaux, de toutes les provinces pour qu'on soit tenu au courant de ce qui se passe partout au Canada et aussi si à votre Ministère de la Santé Nationale vous pouviez faire la diffusion du développement de toutes les provinces aux autres ministeres.

Chairman -

Merci. Concerning the publication of the Federation, Mr. Strehler, are you going to make it widely available?

Mr. Strehler -

We hope that it will be available every three months, Mr. Chairman, and we will be expanding the circulation.

Chairman -

English and French?

Speaker -

Well at the moment the first issue was in English, obviously we wish it to be in French, most certainly.

Chairman -

Can we also expect a review of the provincial programs and developments?

Mr. Strehler -

Well, the news we give is what we find out, and often that is local association activities as you well appreciate. I've learned more about what is going on provincially in the last twenty-four hours than I have in a year, perhaps.

Chairman -

Thank you. May I at this point turn to a couple of additional items? No one has mentioned the possibility of a National conference and I would just mention that the Minister of National Health and Welfare, the Honourable John Munro, has in mind holding a national conference in 1972. I should think that the private sector particularly, including interested individuals, would be invited. It would not be just an official governmental meeting in any sense but would be a very broad meeting in scope and coverage, and invitations would likely be issued to interested agencies, professional organizations, voluntary agencies, and others. Obviously, one of the important purposes would be to bring into the open what is going on in order to make it widely known that this program is meeting an increasing demand on the part of the public.

I am also wondering how complete you would like the record of this particular meeting to be. We can prepare it about any way you want, from verbatim to summaries. I personally feel there has been a great deal of useful information presented and at no place at the moment do we have the amount of information in one place that I think has been presented here since yesterday morning.

Mr. Archibald -

There is no doubt in my mind what I prefer and that is a verbatim.

Chairman -

As complete as possible?

Mr. Archibald -

As complete as possible.

Chairman -

We would intend to edit and to cut out all repetition.

Dr. Khazen -

Is the report of the first conference available?

Chairman -

Not as yet. It's now in the first draft and is being

edited. Are you going to ask that it be made available to you?

Dr. Khazen -

To us, yes please.

Chairman -

Well now, we've come to a point where I know that Dr. Splane as well as myself wish very much to thank each of you. On behalf of all of us in the Department I do want to express appreciation for your interest and for coming, as well as for your participation in the presentations you have made this morning and this afternoon. It is evident that each of you has given considerable time and thought to these reports. About all I can say further is this, that I hope this is an indication of the kind of liaison we will continue to have with you in the coming weeks and months. May I say also that if there is any aspect of this program at all about which you have some doubt, please don't hesitate to write to any one of us in the department and we'll do our very best to try to assist you.

Again many thanks and let me turn you over to Dr. Splane. I am sure he would like to have a word.

Dr. Splane -

The word is a very brief one, Dr. Watkinson. It is simply to underline what you have said and to perhaps comment that Mr. Knight and I have particularly appreciated the opportunity to meet the representatives from the welfare departments and to find out many things that we hadn't known before and to establish contacts which we hope to build upon in the weeks and months ahead as we try to identify for ourselves what the welfare role in family planning is and specifically what our role in the Department of National Health and Welfare is in promoting and advancing that role in collaboration with the provinces and with national and other voluntary agencies.

Dr. Watkinson -

Thank you. The meeting is adjourned.

APPENDIX I

AGENDA

1. Introduction
2. Suggested Objectives and Scope of the Family Planning Program
3. Education and Information Program in Family Planning
4. Federal Program Resources:
   - Hospital and Medical Insurance
   - Canada Assistance Plan
   - National Welfare Grants
   - Professional Training Grant (Health)
   - Health Research Grants
5. Activities of the Family Planning Federation of Canada
6. Le Centre de Planning Familial du Québec Inc.
7. Reports of Provincial Health and Welfare Representatives on Family Planning Activities
8. Potential of Welfare Agencies in Family Planning
9. Potential of Health Agencies in Family Planning
10. Canada's Contribution to International Developments in Family Planning
11. Needs and Priorities

APPENDIX II

SUGGESTED OBJECTIVES FOR THE FAMILY PLANNING PROGRAM

1. To inform Canadians about the purposes and methods of family planning so that the exercise of free individual choice will be based on adequate knowledge.

2. To promote the training of health and welfare professional and other staff involved in family planning services.

3. To promote relevant research in family planning, including population studies and research in human behaviour and reproductive physiology.

4. To support public or private family planning programs through federal grants-in-aid and joint federal-provincial shared cost programs.

5. To cooperate with provincial health and welfare departments, professional organizations, universities and voluntary agencies in the achievement of the foregoing objectives and in ensuring the availability of family planning services and facilities to those who need and desire them.